MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

16739

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Balto
City or town: Lansdowne (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, institution, or~~ street address where death occurred: 33 First Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Lansdowne (If outside city or town limits, write RURAL and give nearest town)
Street No.: 33 First Ave (If rural, give LOCATION)
2.(a) If veteran, name war: N

3.(a) FULL NAME: Adam Abel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife: Effie Abel
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb 13th 1878

8. AGE: Years	Months	Days	If less than one day
68	9	7	..... hrs. ..... min.

9. Birthplace: Balto Md. (Town, county, and state)
10. Usual occupation: Conductor
11. Industry or business: B & O R.R.
12. FATHER — Name: Adam Abel
13. Birthplace: Unknown
14. MOTHER — Maiden name: Magdelina Betzel
15. Birthplace: "
16. Informant: Mrs Effie Abel
Address: 33 - 1st Ave Lansdowne Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/23/46 (month) (day) (year)
Cemetery or ~~crematory~~: London Park
Location: Balto. Md.
18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St.
19. 11/22/46 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 20th 1946, at 6.15 a.m.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3 Hours 1946, to 20 Nov 1946
and that I last saw h.. alive on 19 November 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 Week
Due to: Arteriosclerosis	
Due to:	
Other conditions: Bronchial Asthma	6 years

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward J. Mullen M.D.
M.D. or other
Address: 68 W Washington Blvd Date signed: 20 Nov 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10740

Reg. Dist. No. 381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since May 29, 1943
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since May 29, 1943

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 2024 Park Ave (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Henry Max Ambach

3.(b) Social Security Number: 215-09-1971

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dorothy Ambach 6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Feb 22, 1882

8. AGE: Years: 64 Months: 8 Days: 13 If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business:

FATHER — 12. Name: Max Ambach
13. Birthplace: Fayetteville, Ohio

MOTHER — 14. Maiden name: Ida Bundersheimer
15. Birthplace: Colorado

16. Informant: Personal History-Hospl. Records
Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/5/46 (month) (day) (year)
Cemetery or crematory: Baltimore Hebrew
Location: Balto. Md.

18. Funeral director: Baird Sons & Lee
Address: 1902 Eutaw Place

19. Nov 5 1946 A. W. Nedrich Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3 1946, at 9:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1943, to Nov 3 1946 and that I last saw him alive on November 2 1946

Immediate cause of death: Pulmonary tuberculosis — DURATION: about

Due to: 3 years

Due to: and

Other conditions: 8 mos

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. A. Bridges M. D. or other
Address: Towson 4, Md. Date signed 11-3-46

Dr. Lee Hichew
Northern Pkwy & Belair

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

★ 10741

Reg. Diat. No. 380

1. PLACE OF DEATH:
County: Baltimore-Overlea
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
716 Elmwood Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Overlea
City or town: Baltimore
(If outside city or towo limits, write RURAL and give nearest town)
Street No. 716 Elmwood Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Evelyn Lydia Armstrong

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 9, 1906

8. AGE: Years	Months	Days	If less than one day
40	--	6	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: School Teacher
FATHER 12. Name: James Elwood Armstrong
13. Birthplace: Md.
MOTHER 14. Maiden name: Mary Grace Thomas
15. Birthplace: Md.
16. Informant: Mr. J. Elwood Armstrong
Address: 716 Elmwood Avenue, Overlea
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-18-46 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Baltimore
18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Road-14-
19. 11/18 1946 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15th, 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1946, to Nov 15 1946
and that I last saw h... alive on Nov 15 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	4 days
Due to: Extensive	4 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: A Lee Hichew M.D. (M. D. or other)
Address: 4116 Northern Parkway Date signed: 11/16/46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 19 1945

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

10742 4/0

Reg. Diat. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7013 Dunbar Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: James R. Baskette

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ninnie Baskette
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 28, 1872

8. AGE: Years	Months	Days	If less than one day
74	7	4	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: Thomas Baskette
13. Birthplace: Virginia

MOTHER
14. Maiden name: --
15. Birthplace: --

16. Informant: Roland Baskette
Address: 2920 Salisbury Ave-19

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 5, 1946 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Colgate, Md.

18. Funeral director: Ullrich Funeral Home
Address: 2008 Orleans St.

19. 11/4 19 46 (Date rec'd by registrar) A. K. Hoduck Registrar
1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 2, 1946 19 ..., at 9 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 21, 1945 19 ..., to Nov 2 19 46 and that I last saw h... alive on Nov 2 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to Hypertension Cardio-vascular disease	5 years
Due to Generalized arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Eugene F Neary MD
M. D. or other
Address: 7001 Wolvington Rd Dundalk Md Date signed: 11-3-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

10743

Reg. Dist. No. 381

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years, 11 months, 29 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital (Employee)

How long in hospital or institution? 27 years, 11 months, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)

Street No. Spring Grove State Hospital (If rural, give LOCATION)

2.(a) If veteran, name war -

3. (a) FULL NAME Elmer Lacy Beagle

3. (b) Social Security Number -

4. Sex male

5. Color or race white

6.(a) Single, married, widowed, or divorced Divorced

6.(b) Name of husband or wife Lucy? Collins Beagle

6.(c) If alive, give age ...... years

7. Birth date of deceased (mo., day, yr.) June 26, 1890

8. AGE: Years 56 Months 4 Days 10 If less than one day ...... hrs. ...... min.

9. Birthplace Staunton, Virginia (Town, county, and state)

10. Usual occupation Attendant

11. Industry or business Spring Grove State Hospital

FATHER 12. Name William Baker Beagle

13. Birthplace Laurel Hill, Va.

MOTHER 14. Maiden name Cordelia Tanner

15. Birthplace Laurel Hill, Va.

16. Informant Hospital Records

Address Baltimore 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 9, 1946 (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetery

Location Laurel Hill, Va.

18. Funeral director Wells Lamoreau

Address 1003 W. Baltimore St.

19. 11/7 1946 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1946, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...... 19...., to ...... 19....

and that I last saw h.... alive on ...... 19....

	DURATION
Immediate cause of death Acute Cardiac failure	
Due to	
Due to Chronic Alcoholism	
Other conditions sudden death Inquiry	

(Include pregnancy within 3 months of death)

Major findings of operations ...... Date of op. ......

Autopsy results ......

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ...... Date of ......

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ...... Injured at work? ......

23. SIGNATURE ~~[illegible]~~ Geo. M. Kieffer Deputy Exam. of Balto. M. D. or other

Address 1010 Leeds ave Date signed Nov 6-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10744

Reg. Dist. No. 430

1. PLACE OF DEATH:
County Balto
City or town Perry Hall
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred: Penn Ave.
How long in hospital or institution? 4

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto.
City or town Perry Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No. Penn Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alvie R. Becker

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband or wife: Paul E. Becker
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Feby. 1875
8. AGE: Years 71 | Months 8 | Days — | If less than one day ..... hrs. ..... min.
9. Birthplace: Md —
(Town, county, and state)
10. Usual occupation: house duties
11. Industry or business
FATHER 12. Name: Thomas Bussey
13. Birthplace: Md.
MOTHER 14. Maiden name: Octavia Stonebraker
15. Birthplace: Md
16. Informant: Margaret K. Slater
Address: 2501, Roslyn Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 29/46 (month) (day) (year)
Cemetery or crematory: Baltimore
Location: Loth Ave. & Gwynn St.
18. Funeral director: John O. Mitchell & Sons
Address: 1900 Eutaw Place
19. Nov. 26 1946 (Date rec'd by registrar) A. W. Dennis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1946, at 11 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5 1946 to Nov. 25 1946
and that I last saw her alive on Nov. 25 1946

	DURATION
Immediate cause of death: Congestive Heart Failure	2 Mos
Due to: Hypertension Cardiovascular Dis.	4 yrs.
Due to:	
Other conditions: Cholecystitis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Clifford P. Hudson M.D.
M. D. or other
Address: Fork, Md. Date signed 11/26/46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 26 1946
BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

10745 4

Reg. Dist. No. 301

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 3 mos. 19 days
Hospital, Institution, or street address where death occurred: Spring Grove State Hosp.
How long in hospital or institution? 3 yrs. 3 mos. 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Baltimore
City or town Parkville (If outside city or town limits, write RURAL and give nearest town)
Street No. 3204 Willoughby Rd. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Effie Pearl Bedwell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife Horace Lee Bedwell
6.(c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) December 27, 1890

8. AGE:

Years	Months	Days	If less than one day
55	10	7	....hrs. ....min.

9. Birthplace Kentucky (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business None
FATHER 12. Name Andrew McClain Roach
13. Birthplace Kentucky
MOTHER 14. Maiden name Cecelia Collie
15. Birthplace Kentucky
16. Informant Hospital Records
Address Catonsville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-6-46 (month) (day) (year)
Cemetery or crematory Maryland Pk.
Location Baltimore
18. Funeral director Leonard J. Ruck
Address 5306 Harford Rd.
19. Nov 5 1946 (Date rec'd by registrar) C. Wittstadt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1946, at 7:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1943, to Nov. 3 1946 and that I last saw her alive on Nov. 3 1946

	DURATION
Immediate cause of death: Coronary Thrombosis	Several hours
Due to: Hypertension Cardio-vascular Disease	1 yr.
Other conditions: Ventral Hernia	18 yrs.

(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op.
Autopsy results Not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Andrew Funk, M.D. M. D. or other
Address Spring Grove State Hosp. Date signed 11-7-46

VS/A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 10746 38P

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 Dumbarton Road
(c) Hospital or institution St. Joseph
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTIMORE
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Dumbarton Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALBERTINA BEHM

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Carl Behm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1884

8. AGE: Years	Months	Days	If less than one day
62	7	14	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Tjark Susemihl
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Carl Behm
(b) Address 413 Dumbarton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) 11-25-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1946, at 10.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 5 1946 to Nov. 21 1946, and that I last saw h.. alive on Nov 21 1946

Immediate cause of death Pulmonary Tuberculosis (Positive Sputum.) — Duration years?

Due to

Due to

Other Conditions Carcinoma of uterus treated by radiation 1939
(Include pregnancy within 3 months of death)

Date of operation None since 1939

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Chaffour M.D.
Address 6710 York Rd Date signed Nov. 22 46

VS 150 1-25 2-38-1-10

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

★ 10747

Reg. Dist. No. 36-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Emma Road
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State: Maryland County: Baltimore
City or town: Parkton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Thomas Bell

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): February 23, 1881

8. AGE:

Years	Months	Days	If less than one day
65	8	14	____ hrs. ____ min.

9. Birthplace: Mt. Carmel, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm.

FATHER
12. Name: James Bell.
13. Birthplace: Scotland.

MOTHER
14. Maiden name: Martha E. Martin
15. Birthplace: Balto. Co., Md.

18. Informant: Mrs. William Bell.
Address: Freeland, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 11, 1946 (month) (day) (year)
Cemetery or crematory: Pine Grove M. E.
Location: Parkton, Md. R. D.

18. Funeral director: Jacob Hartenstein
Address: New Freedom, Pa.

19. Nov 7 1946 (Date rec'd by registrar) Charles L. Fuellhorn Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7 1946, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None to ____ 19____,
and that I last saw h____ alive an____ 19____.

Immediate cause of death: Heart disease, coronary with coronary occlusion — DURATION: 1 day
Due to: Arteriosclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Rollin C. Hudson M.D. M. D. or other
Address: Towson Md. Date signed 11/7/46.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 10748 38 1

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ~~1 mo~~ 1½ yrs
Hospital, institution, or street address where death occurred:
312 W. Chesapeake Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 305 Bosley Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Alice Herbert Bowen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ Charles T. Bowen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 15, 1860

8. AGE: Years	Months	Days	If less than one day
86	3	17	— hrs. — min.

9. Birthplace Catonsville, Balto. Co., Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home

FATHER
12. Name Gideon Herbert
13. Birthplace Penna.

MOTHER
14. Maiden name Elizabeth Filmyer
15. Birthplace Penna.

16. Informant Mrs. Harry D. Williams
Address 312 W. Chesa. Ave., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4 1946 (month) (day) (year)
Cemetery or crematory Druid Ridge Cemetery
Location Pikesville Maryland

18. Funeral director John Burns Sons
Address Towson Maryland

19. Nov. 4 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2, 1946 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 46 to Nov 1, 46 and that I last saw h[illegible] alive on Nov 1, 1946

Immediate cause of death	DURATION
Apoplexy	2 wks.
Due to Arteriosclerosis	
Due to Hypertension	unk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Towson 4 Md Date signed 11/4/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-7

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Balto.
City or town Parkeville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Parkeville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3042 Edgewood Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Eva Janetta Bowers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.M.	W.	Married

6.(b) Name of husband or wife Henry Bowers
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1879

8. AGE: Years	Months	Days	If less than one day
66	11	27	..... hrs. ..... min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual occupation at home
11. Industry or business

MOTHER FATHER
12. Name Robert Gradamond West
13. Birthplace Georgia
MOTHER
14. Maiden name Mary Ann Butterfield
15. Birthplace West Indies

16. Informant Jessie Taylor McClain
Address 3042 Edgewood Road

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 11 / 11 / 46 (month) (day) (year)
Cemetery or crematory Parkwood
Location Bayley Ave.

18. Funeral director Leonard J. Rucks
Address 5305 Harford Road

19. Nov. 11 1946 A.W. Hedrick A.S. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 November 1946 at 3 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10 1946 to 6 Nov. 1946 and that I last saw h.. alive on 6 November 1946

Immediate cause of death	DURATION
H Emorrhage, gastric, ulcer	1 day
Due to: Metastatic carcinoma	3 mos.
Due to: Primary Carcinoma of tonsil	3 mos.
Other conditions: None.	

(Include pregnancy within 3 months of death)

Major findings of operations None.
Date of op. None.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edward J. Mohr M.D.
Address 7329 Harford Rd. Balto. 14, Md. M.D. or other
Date signed 8 Nov 46.

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yr. 11 mo. 5 da.

Hospital, institution, or street address where death occurred:
Baltimore County Home

How long in hospital or institution? 3 yr. 11 mo. 5 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Timonium
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Martin Brendle

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 7, 1878

8. AGE: Years	Months	Days	If less than one day
68	1	5	hrs. min.

9. Birthplace: New York City N. Y.
(Town, county, and state)

10. Usual occupation: Horseman (Race Horses)

11. Industry or business:

FATHER
12. Name: Henry Brendle
13. Birthplace: unknown

MOTHER
14. Maiden name: Catherine (unknown)
15. Birthplace: Unknown

16. Informant: Baltimore Co. Home Register
Address: Texas, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 13 1946 (month) (day) (year)

Cemetery or crematory: Baltimore County Home Cem.

Location: Texas, Md.

18. Funeral director: Landon Brooks

Address: Sparks, Md.

19. Nov 13 1946 (Date rec'd by registrar) Wm J. Whitlock Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 12 1946, at 5 55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/7 1942 to 11/12 1946 and that I last saw him alive on 11/12 1946.

Immediate cause of death	DURATION
Carcinoma - (Primary Rectal)	3 yrs -
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Euson M.D.
M. D. or other

Address: Cockeysville Md Date signed: 11/18/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

P 10751

Reg. Diat. No. 301

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 38 Lincoln Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Floyd A. Brooks

3.(b) Social Security Number 216-07-1983

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Louise L.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 10, 1896

8. AGE: Years	Months	Days	If less than one day
50	8	12	..... hrs. ..... min.

9. Birthplace Reedsville, Va
(Town, county, and state)
10. Usual occupation Stevedore
11. Industry or business
FATHER 12. Name James Brooks
13. Birthplace Reedsville, Va
MOTHER 14. Maiden name Mary Davis
15. Birthplace Reedsville, Va
16. Informant Louise L. Brooks
Address 38 Lincoln Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 26 1946 (month) (day) (year)
Cemetery or crematory Catonsville Mem. Park.
Location Baltimore Co. Md.
18. Funeral director George W. Holland
Address 1631 Druid Hill Ave.
19. 11/26/46 19..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 19 46, at 6.45 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-19-46 19..... to 11-22- 19 46
and that I last saw h.. alive on 11-22-46 19.....

	DURATION
Immediate cause of death	
Coronary Artery Occlusion	3 days
Due to Arteriosclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. F. Maloney M.D.
M. D. or other
Address Catonsville Md. Date signed 11-22-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10752 Reg. Diat. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 9 months, 1 day

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 2 years, 9 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Calvert

City or town: Lusby's (If outside city or town limits, write RURAL and give nearest town)

Street No.: none (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Julius L. Buckler

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: —

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 21, 1895

8. AGE: Years	Months	Days	If less than one day
51	4	4	..... hrs. ..... min.

9. Birthplace: Cove Point, Calvert County, Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER 12. Name: William W. Buckler

FATHER 13. Birthplace: Calvert County, Maryland

MOTHER 14. Maiden name: Dorcus A. Denton

MOTHER 15. Birthplace: Calvert County, Maryland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/27/46 (month) (day) (year)

Cemetery or crematory: St. Paul Cem.

Location: Lusby's, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 11/26 (Date rec'd by registrar) 19 46 R W Hebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25, 1946, at 4:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 24, 1944, to November 25, 1946 and that I last saw him alive on November 25, 1946

Immediate cause of death: Myocardial insufficiency, chronic--indef. — DURATION

Due to: Pulmonary tuberculosis? — indefinite

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 11-25-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-a)

CERTIFICATE OF DEATH

★ 10753 446 Reg. Diat. No.

1. PLACE OF DEATH:
County Baltimore Co.
City or town Sparrow Pt.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
810 - E. 4th.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md. County Baltimore
City or town Sparrow Pt.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 810 - E. 4th.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Catherine M. Burkhouse | **3. (b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Edward.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) June 23 / 1900

8. AGE:

Years	Months	Days	If less than one day
46	5		..... hrs. ..... min.

9. Birthplace Pittsburg Pa. (Town, county and state)
10. Usual occupation Housewife
11. Industry or business

MOTHER FATHER
12. Name Peter O'Bringer
13. Birthplace Germany
14. Maiden name Margaret Francisous
15. Birthplace Germany

16. Informant E. Burkhouse
Address 810. E. 4th.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 11/27-46 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Eastern Road
18. Funeral director John A. Hagan
Address 3000 E. Balto. St.

19. NOV 25 - 1946 Dawson L. Harbor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 - 1946, at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 - 1946, to Nov 23 - 1946 and that I last saw her alive on Nov 23 - 1946

Immediate cause of death	DURATION
Cardiac Failure	3 days
Due to Calcification of aortic Valve with Stenosis	Two yrs.
Due to Auricular fibrillation	5-months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dawson L. Harbor, M. D. or other
Address Sparrows Point Md Date signed 11/25/46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

10754

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:
County: Balto
City or town: St Georges (Reislerstown)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred:
Bond & Central Avenues
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: St Georges
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bond & Central Avenues
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Walter Lightbourne Butler

3.(b) Social Security Number: 216-01-4123 A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Augusta Weisheit Butler
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): March 21 1872

8. AGE:

Years	Months	Days	If less than one day
74	7	22	...hrs. ...min.

9. Birthplace: St Michaels Md Talbot County
(Town, county, and state)
10. Usual occupation: Retired Engr
11. Industry or business: -

FATHER
12. Name: Christopher C Butler
13. Birthplace: Virginia

MOTHER
14. Maiden name: Sarah Jones
15. Birthplace: StMichaels Md

16. Informant: Mrs Lillian B. Kurts
Address: 3310 Fait Ave Balto Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 13 1946 (month) (day) (year)
Cemetery or crematory: Pleasant Grove Cemetery
Location: Boring Md

18. Funeral director: Wm Berryman & Sons
Address: Reisterstown Md

19. 11-11-1946 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 November 1946 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 Nov 1946 to 11 Nov 1946 and that I last saw h.. i.. alive on 8 Nov 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 mos.
Due to: Arteriosclerosis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: H. F. Ernshaw, M.D.
M. D. or other
Address: Reisterstown, Md. Date signed 11 Nov 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-6)

CERTIFICATE OF DEATH

10755

Reg. Dist. No.

1. PLACE OF DEATH:
County Baltimore Parkville
City or town 3303 Putty Hill Ave
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3303 Putty Hill Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martin J. Callahan

3.(b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widow

6.(b) Name of husband or wife Annie

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 2 1882

8. AGE: Years 64 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Cornack Callahan
13. Birthplace Ireland

MOTHER 14. Maiden name Annie Bradshaw
15. Birthplace Ireland

16. Informant Annie M. Callahan
Address 3303 Putty Hill Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 30 1946 (month) (day) (year)

Cemetery or crematory New Cathedral
Location Old Frederick Road

18. Funeral director John C. Moran
Address 3600 E Baltimore St

19. 11/29 1946 (Date rec'd by registrar) C. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1946, at 9.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21 1946 to Nov 27 1946 and that I last saw h. alive on Nov 27 1946

Immediate cause of death	DURATION
Carcinoma of Stomach	6 mos.
Due to	
Due to	
Other conditions Arteriosclerosis, generalized. Arteriosclerotic Heart Disease. Anemia, pernicious	Indefinite 10 yrs. 10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edward J. Cotter M. D. or other
Address 11 E. Chase St. Date signed Nov 29 1946

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:
County Baltimore
City or town Texas
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yr. 8 mo. 7 da
Hospital, Institution, or street address where death occurred:
Baltimore County Home
How long in hospital or institution? 5 yr. 8 mo. 7 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Texas
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Harry Carrol

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 6, 1872

8. AGE: Years	Months	Days	If less than one day
74	4	4	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business

FATHER
12. Name George Carrol
13. Birthplace Maryland

MOTHER
14. Maiden name Nellie Hyland
15. Birthplace Maryland

16. Informant Baltimore County Home Register
Address Texas, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Nov. 11 1946
(month) (day) (year)

Cemetery or crematory Balto. Co. Home Cem.
Location Texas, Md.

19. Funeral director Landon Brooks
Address Sparks, Md.

19. 11/11/46 19 46 (Date rec'd by registrar) Wm. J. Whitlock Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1946 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/3 1946 to 11/10 1946 and that I last saw him alive on 11/9 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to Arterio Sclerosis	
Due to Hypertension — Senility —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilmer C. Ensor M.D
M. D. or other
Address Cockeysville Md Date signed 11/11/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 13 1946
BUREAU V &

1-25

2-370

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32a1

10757

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Fort Howard, Md.
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1137 Valley St.
(If rural, give LOCATION)
2.(a) If veteran, name war WWI

3.(a) FULL NAME JOHN ARTHUR CLASBY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Rhea Clasby
6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1897

8. AGE: Years	Months	Days	If less than one day
49	2	10	..... hrs. ..... min.

9. Birthplace Boston, Mass.
(Town, county, and state)
10. Usual occupation Guard
11. Industry or business Edgewood Arsenal

FATHER
12. Name Thomas H.
13. Birthplace Boston, Mass.

MOTHER
14. Maiden name O'Leary
15. Birthplace Boston, Mass

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Ft. Howard, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 11/23/46 (month) (day) (year)
Cemetery or ~~crematory~~ Balto
Location " Md.
18. Funeral director Wm. Cook
Address St. Paul & Preston Sts., Balto., Md.

19. 11/22 1946 (Date rec'd by registrar) A. to Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 19 46, at 5:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 14 19 46, to Nov. 20 19 46 and that I last saw him alive on Nov. 20 19 46

Immediate cause of death	DURATION
Acute and Chronic Infectious hepatitis	3 Mos.
Due to	
Due to	
Other conditions Edema of brain and lungs	2 Days

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison
R.M. CULLISON, M.D. CLIN. DIRECTOR
Address V.A. Ft. Howard, Md. Date signed 11-21-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45

1946 - 11 - 20
1897 - 9 - 10
49 - 2 - 10

SURNAME: Letter fromH.C.BICKEL, attorney, and PALTO.CO.REG.WILLS CER. filmed 11-21-46G108LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 10758 4/1

1. PLACE OF DEATH:
County Baltimore
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 701 Eastern Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Agnes CRENNING

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Myra Krenning (nee Brown)
6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov. 27th 1885

8. AGE: Years 60 | Months 11 | Days 13 | If less than one day ... hrs. ... min.

9. Birthplace Milltown, N. Jersey
(Town, county, and state)

10. Usual occupation Director (Retired)

11. Industry or business Glenn L. Martin Co.

FATHER 12. Name William N. Krenning CRENNING

13. Birthplace New Jersey

MOTHER 14. Maiden name Mary Agnes

15. Birthplace New Jersey

16. Informant Mrs. Myra Krenning CRENNING
Address 701 Eastern Ave. Essex

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Nov. 10-46 (month) (day) (year)

Cemetery or crematory Van Liew

Location New Brunswick, N. J.

18. Funeral director John G. Connelly

Address 418 Eastern Ave. Essex

19. Nov. 10 1946 John G. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1946, at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10th 1946, to November 10th 1946 and that I last saw h.. alive on November 10th 1946

Immediate cause of death	DURATION
Uraemic Myocarditis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. White, M.D.
M. D. or other
Address 1601 Eastern Ave Baltimore 24, Md. Date signed 11/10/46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-2)

CERTIFICATE OF DEATH

10759

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore,
City or town: Towson,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 16 East Burke Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore,
City or town: Towson,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 16 East Burke Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Curran,

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Catherine E. Curran,
6.(c) If alive, give age: --

7. Birth date of deceased (mo., day, yr.): March 4, 1869

8. AGE: Years	Months	Days	If less than one day
77	8	21	hrs. min.

9. Birthplace: Baltimore City,
(Town, county, and state)
10. Usual occupation
11. Industry or business: Fruit & Produce Business,
FATHER 12. Name: Edward Curran,
13. Birthplace: Ireland.
MOTHER 14. Maiden name: Mary Hogan,
15. Birthplace: Ireland.
16. Informant: Mrs. Catherine E. Curran,
Address: 16 E. Burke Ave., Towson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/28/46 (month) (day) (year)
Cemetery or crematory: Cathedral,
Location: Baltimore City,
18. Funeral director: C. Vernon Lemmon
Address: 4611 Park Heights, Balto. Md.
19. 11/26 1946 (Date rec'd by registrar) D. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25, 1946 at 6 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1946, to 11/25 1946
and that I last saw him alive on 11/23 1946

Immediate cause of death: Respiratory Failure — DURATION: 3 Days
Due to: Metastatic Cancer of Lung — 6 Months
Due to: Primary Prostate Cancer — 3 yrs
Other conditions: Cancer (Primary) of Prostate — 2 yrs
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles F. O'Donnell M.D.
M. D. or other
Address: 7301 York Road. Date signed 11/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

* 10760

Reg. Dist. No. 32 1

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 10 mos., 20 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 10 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 160 Davis Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mr. Alvin Davis

3. (b) Social Security Number: # Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Esther Davis

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 27, 1915

8. AGE: Years	Months	Days	If less than one day
31	9	26	..... hrs. ..... min.

9. Birthplace: Snow Hill, Maryland (Town, county, and state)

10. Usual occupation: Service Station Attendant

11. Industry or business:

FATHER — 12. Name: Goldsboro Davis

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Adda Parsons

15. Birthplace: Maryland

16. Informant: Mr. Alvin Davis

Address: 160 Davis St., Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 26, 1946 (month) (day) (year)

Cemetery or crematory: Wango Meth. Church Cem.

Location: Salisbury, Maryland

18. Funeral director: Holloway Company

Address: Salisbury, Maryland

19. Nov. 22, 1946 (Date rec'd by regietrar) Earl T. Webster Regietrar

Rec'd. 11-26-46

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22, 1946 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1946, to Nov. 22, 1946

and that I last saw him alive on November 22, 1946

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 1 Yr.

Due to: Tubercle Bacilli

Due to:

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operation: No operation — Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. (M. D. or other)

Address: Mount Wilson, Md. Date signed: 11/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10761 P

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Fort Howard, Maryland
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 minutes
Hospital, institution, or street address where death occurred:
Veterans Administration, Fort Howard, Md.
How long in hospital or institution? 45 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 604 N. Ellwood Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war WW II

3.(a) FULL NAME
Stanley Foster Dieterly

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/22/28

8. AGE: Years	Months	Days	If less than one day
18	9	19	hrs. min.

9. Birthplace Baltimore, Maryland (town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Benjamin Dieterly
13. Birthplace Baltimore

MOTHER
14. Maiden name Gertrude Foster
15. Birthplace Baltimore

16. Informant Clinical Records
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 16 /46 (month) (day) (year)
Cemetery or crematory ******** Oak Lawn Cem.
Location Balto. Md.

18. Funeral director Phillip Herwig Sons
Address Castle & Orleans Sts., Balto., Md.

19. 11-14-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1946 11:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 11 1946, to November 11 1946 and that I last saw h... im alive on November 11, 1946

Immediate cause of death MYELOENCEPHALIS, ACUTE, ETIOLOGY, UNDETERMINED — DURATION: 3 days

Due to

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work? 11-[illegible]-46

23. SIGNATURE Robert M. Cullison
R.M. CULLISON, M.D. Clin. Dir.
M. D. or other
Address VA. Fort Howard, Md. Date signed 11-12-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10762

Reg. Dist. No. 43 O

1. PLACE OF DEATH:

County: Balto.

City or town: Raspe burg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs.

Hospital, Institution, or street address where death occurred: 7673 Belair Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Raspeburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 7673 Belair Rd. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Arthur T. Donaldson

3.(b) Social Security Number: 216-10-560

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Christina Donaldson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10th 1876

8. AGE: Years	Months	Days	If less than one day
70	5	11	hrs. min.

9. Birthplace: Carroll Co Md. (Town, county, and state)

10. Usual occupation: Bricklayer

11. Industry or business

FATHER — 12. Name: Arthur M. Donaldson

FATHER — 13. Birthplace: —

MOTHER — 14. Maiden name: —

MOTHER — 15. Birthplace: —

16. Informant: Mrs. A.T. Donaldson

Address: 7673 Belair Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/23/46 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Balto. Md

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Rd.

19. Nov 22 1946 (Date rec'd by registrar) Mrs. A.L. Rufsnyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 21st 1946, at 1 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11/16 1946, to 11/21 1946 and that I last saw h[illegible] alive on 11/21 1946

Immediate cause of death	DURATION
CEREBRAL THROMBOSIS	5 days
Due to: CEREBRAL ARTERIOSCLERO[illegible]	[illegible]
Due to:	
Other conditions: ARTERIAL HYPERTENSION	5 Yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. E. Madden M.D. M. D. or other

Address: 6331 Belair Rd. Date signed: 11/24/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

RECEIVED
NOV 27 1946
BUREAU V.E.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

10763

Reg. Diat. No. 441

1. PLACE OF DEATH:
County Balto.
City or town Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ebenezer Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Margaret Anna Edwards

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Thomas H. Edwards
6.(c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) Oct. 26 - 1895

8. AGE: Years	Months	Days	If less than one day
51	1	3	hrs. min.

9. Birthplace Howard Co. Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Geo. M. Hardy
13. Birthplace Howard Co. Md.
MOTHER 14. Maiden name Sarah Meridith
15. Birthplace Howard Co. Md.
16. Informant Mr. Thomas Edwards
Address Ebenezer Rd. Chase, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 3 - 46 (month) (day) (year)
Cemetery or crematory Piney Grove
Location Mt. Airy Md.
18. Funeral director John J. Connelly
Address 418 Eastern Ave. Essex
19. Dec. 3 1946 John J. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29th 19 46, at 1:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19 45 to Nov 29 19 46 and that I last saw h.. alive on Nov 29 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hours
Due to Hypotension	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Norman B. Hayley, M.D.
M. D. or other
Address 815 Eastern Ave Date signed Dec 7, 1946

1-25-2-440-1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 44 — 10764

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 2 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 1 month, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 811 Essex Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George Eisman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	separated

6.(b) Name of husband or wife: Katie Cullum

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 7, 1879

8. AGE: Years	Months	Days	If less than one day
67	6	10	..... hrs. ..... min.

9. Birthplace: Baltimore City
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Grocery store

FATHER
12. Name: John Eisman
13. Birthplace: ?

MOTHER
14. Maiden name: Mary Ruhl
15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/21/46 (month) (day) (year)

Cemetery or crematory: Sacred Heart

Location: German Hill Rd.

18. Funeral director: John G. Connelly

Address: 418 Eastern Ave. Edgewood, Md.

19. 11-21-46 (Date rec'd by registrar) 19..... John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 17 19 46 at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 19 46 to November 17 19 46 and that I last saw him alive on November 17 19 46

	DURATION
Immediate cause of death: Chronic myocardial insufficiency	indefinit
Due to: Generalized arteriosclerotic cardiovascular disease	"
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed 11-18-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-a)

CERTIFICATE OF DEATH

★ 10765

Reg. Dist. No. 441

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore - 22
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hours.
Hospital, Institution, or street address where death occurred: Box 110 - Mt. Pt. Rd. at. near Battle Grove
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Same as # 1 County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street and No.: (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elsie Reba Evans

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 9. 1946.

8. AGE:

Years	Months	Days	If less than one day
			2 hrs. 10 min.

9. Birthplace: as in # 1. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Woodrow Hall.
13. Birthplace: Unknown.

MOTHER
14. Maiden name: Marnida Evans.
15. Birthplace: Prince Edward Co. Va

16. Informant: Marnida Evans.
Address: as in # 1.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 9-46 (month) (day) (year)
Cemetery or crematory: Methodist Cem. (Col)
Location: Rose Cem & North Pt. Pk

18. Funeral director: John F. Connelly
Address: 418 Eastern Ave. Grave

19. Nov 9 ct 1946 (Date rec'd by registrar) John F. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 9. 1946, at 8 10/A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 9 46 to Nov. 9 46
and that I last saw her alive on Nov. 9. 1946.

Immediate cause of death	DURATION
Atalectasis	2 hr 10 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis N. Tollini. M.D.
M. D. or other
Address: Sparrows Pt. md. Date signed 11/9/46

RECEIVED
DEC 4 1946
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2-25

2-440- 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

CERTIFICATE OF DEATH

Reg. Dist. No. 10766 281

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years, 5 months, 16 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 7 years, 5 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3908 N. Charles Street (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary Fairfax

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: A. P. Fairfax

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 19, 1867

8. AGE: Years	Months	Days	If less than one day
79	2	7	hrs. min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: ?

11. Industry or business: ?

FATHER 12. Name: ?

FATHER 13. Birthplace: ?

MOTHER 14. Maiden name: ?

MOTHER 15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 28-4 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore

18. Funeral director: Stuart Memorial Co.

Address: 1080 Mont. Balto.

19. Nov. 28 19 46 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26 19 46 at 4:35 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Terminal Pneumonia	
Due to Cardio Vascular disease	
Due to Fracture of left hip	
Other conditions accident	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: I am

Accident, suicide, or homicide: Accident Date of 11-11-46

Where did injury occur? Catonsville Balto Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): hospital

Means of injury: Fall out of bed Injured at work? no

23. SIGNATURE: Geo. M. Leffler Asst Med Supt (M. D. or other)

Address: 1010 Leeds ave Date signed: 11-26-46

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NOV 26 1945
BUREAU
1-95

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

163 M

10767

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:

County: Balto.

City or town: R. F. D. - Glyndon

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Near Glyndon

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Leo Thomas Fallon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Nov. 9, 1914

8. AGE: Years	Months	Days	If less than one day
32		21	...hrs. ...min.

9. Birthplace: Baltimore City (Town, county, and state)

10. Usual occupation: Jockey

11. Industry or business

FATHER — 12. Name: Thomas Leo Fallon

FATHER — 13. Birthplace: Baltimore City

MOTHER — 14. Maiden name: Mary A. Ryan

MOTHER — 15. Birthplace: Baltimore Co.

16. Informant: Thomas Leo Fallon

Address: 5607 Merville Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 2, 1946 (month) (day) (year)

Cemetery or crematory: New Catherdal

Location: Baltimore City

18. Funeral director: C. Vernon Lemmon

Address: 4611 Park Heights Ave. Baltimore

19. 11-30-1946 (Date rec'd by registrar) Mary B. F. Line Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 1946, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-30-'46 1946, to 11-30-'46 1946

and that I last saw him alive on not seen alive 1946

Immediate cause of death	DURATION
Carbon Monoxide Poisoning	2 hrs. estimated
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 11-30-'46

Where did injury occur? Glyndon, Balto., Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Garage-Sagamore Farm

Means of injury: Injured at work? No

23. SIGNATURE: D. D. Eagles Med. Examiner M. D. or other

Address: Reisterstown, Md. Date signed: 11-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 4 1916
DEPT. OF STATE

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10768

Reg. Dist. No. 440

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 206 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Md.

How long in hospital or institution? 206 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 507 S. Caroline St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME
JAMES L. FRANKLIN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Sarah Franklin

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): December 24, 1889

8. AGE: Years	Months	Days	If less than one day
56	11	3	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Chef Cook

11. Industry or business

FATHER
12. Name: George Franklin (Dec.)
13. Birthplace: Delaware

MOTHER
14. Maiden name: Esther Concress (Dec.)
15. Birthplace: Pennsylvania

16. Informant: Clin. Rec. Vets. Adm. Hospital
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/3/46 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore, Md.

18. Funeral director: Elroy Wilson

Address: 1510 Orleans St., Balto., Md.

19. 12-2 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 19 46 at 6:21 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on November 28 19 46

Immediate cause of death: TUBERCULOSIS CHRONIC PULMONARY — DURATION: since 5-6-46 plus

FAR ADVANCED

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D., CLIN. DIR.
M. D. or other

Address: V.A. Ft. Howard, Md. Date signed:

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

10769 310

CERTIFICATE OF DEATH

Reg. Dist. No.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45

1. PLACE OF DEATH: County Baltimore
City or town Woodlawn (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Baltimore
City or town Woodlawn (If outside city or town limits, write RURAL and give nearest town)
Street No. 6037 Gwyn Oak Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bridget Mary Gairty
3.(b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife John
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Aug. 4, 1869
8. AGE: Years 77 Months Days If less than one day ... hrs. ... min.
9. Birthplace Ireland (Town, county, and state)
10. Usual occupation —
11. Industry or business —
FATHER 12. Name Wm Delaney
13. Birthplace Ireland
MOTHER 14. Maiden name Marg Morresey
15. Birthplace Ireland
16. Informant William D Gaierty
Address 153 Collins Ave
17. Burial (Burial, cremation, or removal, Which?) Date thereof 11-9-1946 (month) (day) (year)
Cemetery or crematory St Peters
Location Baltimore, Md.
18. Funeral director Flynn & Fleming
Address 1426 Light St
19. 11/8 1946 (Date rec'd by registrar) A.W. Hedrich Jm. Registrar

1-25

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6/ 1946, at 3 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/12 1946, to 11/6/ 1946
and that I last saw her alive on 11/5 1946

Immediate cause of death Congestive Heart Failure — DURATION 24 hrs.
Due to Myocardial Failure c Sen. Arteriosclerosis
Due to Sen. Debility
Other conditions none
(Include pregnancy within 3 months of death)
Major findings of operations none
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Chas. Norton, Jr. M. D. or other
Address 1933 W. Balto. St Date signed 11/6/46

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

10770

Reg. Dist. No. 31 0

1. PLACE OF DEATH:
County Baltimore
City or town Harrisonville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
Randallstown Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Harrisonville (If outside city or town limits, write RURAL and give nearest town)
Street No. Randallstown P O Md (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Annie Core George

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife Stephen F George
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 19th 1864

8. AGE: Years	Months	Days	If less than one day
81	11	14	..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation H W.
11. Industry or business at home
12. FATHER Name John Core
13. Birthplace Ireland
14. MOTHER Maiden name Ann Warwick
15. Birthplace Baltimore Md
16. Informant Margaret George
Address Randallstown Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof 11/6/46 (month) (day) (year)
Cemetery or crematory Loudon Park
Location Baltimore Md
18. Funeral director Wm. J. Tuckerman & Sons
Address North & Penna Ave
19. 11/3/1946 Wm E. Martin Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1946, at 2.40 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 29th 1946, to Nov. 3, 1946
and that I last saw h.. alive on Nov. 3, 1946

	DURATION
Immediate cause of death Uremic Poisoning	
Due to Acute Nephritis (glomerular)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Wm E. Martin M. D. or other
Address Randallstown, Md Date signed 11/3/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 6 1946
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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-e

CERTIFICATE OF DEATH

Reg. Diat. No. 107744

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:

Veterans Administration, Fort Howard, Md.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3214 Elgin Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME Vincent Geraghty

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/7/1893

8. AGE: Years 53 | Months 10 | Days 4 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Guard

11. Industry or business

FATHER 12. Name Patrick Geraghty

13. Birthplace England

MOTHER 14. Maiden name Kate Dougherty Geraghty

15. Birthplace Ireland

16. Informant Clinical Records

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-14-46 (month) (day) (year)

Cemetery or crematory Priv. Cem.

Location New Cathedral Cem.

18. Funeral director Martin Fahay

Address 138 Light St., Baltimore, Md.

19. 11-13 46 (Date rec'd by registrar) (19) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1946, at 8:20 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 9 1946, to November 11 1946

and that I last saw him alive on November 11 1946

Immediate cause of death	DURATION
Failure of right ventricle Cor pulinonale	Unknown
Due to Pulmonary fibrosis and emphysema	Unknown
Due to	
Other conditions Obesity: Chr. bronchitis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison

R. M. CULLISON, M.D. CLIN. DIR.

Address V.A. Ft. Howard, Md. Date signed 11-12-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

* 10772

Reg. Diat. No. 301

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
519 Academy Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 519 Academy Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles H Goetz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Catherine A
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 17 1864

8. AGE: Years: 82 | Months: 7 | Days: 26 | If less than one day: hrs. min.

9. Birthplace: Penna
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Godfrey Goetz
13. Birthplace: Germany

MOTHER
14. Maiden name: Ellen Graham
15. Birthplace: Penna

16. Informant: Mrs Lucian M Woods
Address: 519 Academy Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-14-46 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore Md

18. Funeral director: George C Tinley
Address: Catonsville Md

19. 11-14-1946 (Date rec'd by registrar) Harry D. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12 1946, at 7.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1946, to November 12 1946 and that I last saw h alive on November 11 1946.

Immediate cause of death	DURATION
Senility	Yrs.
Due to: Generalized arteriosclerosis	7.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilson K. Gallagher M.D.
M. D. or other
Address: Catonsville 28, Md. Date signed 11-13-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

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1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

10773 P

Reg. Dist. No. 710

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Balto
City or town: Turners Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Turners Station
(If outside city or town limits, write RURAL and give nearest town)
Street No. 116 Carver Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME 650 Andrew Green

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	—

6.(b) Name of husband or wife: Aug 27 - 46
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug 27, 1946

8. AGE: Years | Months: 2 | Days: 19 | If less than one day: hrs. min.

9. Birthplace: Turners Station (City)
(Town, county, and state)

10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Levi Green
13. Birthplace: N. C.

MOTHER
14. Maiden name: Avery Watson
15. Birthplace: N C

16. Informant: Levi Green (?)
Address: 116 Carver Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/16/46 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Balto City

18. Funeral director: Isaac L. Brown
Address: 108 W Monroe St

19. 11-15 19 46 (Date rec'd by registrar) Registrar

P-35

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1946 at 1 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 14, 1946 to November 14, 1946
and that I last saw h alive on Dead on arrival 19
Immediate cause of death: Cardiac Failure — DURATION

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William G. Hale M.D.
M. D. or other
Address: 140 Oak Ave Date signed 11-14-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

★10774 P

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12-1/2 Hrs.
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
How long in hospital or institution? 12-1/2 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Balto
City or town Fort Howard (If outside city or town limits, write RURAL and give nearest town)
Street No. 12 Blank Ave., (If rural, give LOCATION)
2.(a) If veteran, name war SAW--Ret.

3.(a) FULL NAME GEORGE D. GRUNINGER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna Gruninger
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-26-1874

8. AGE: Years	Months	Days	If less than one day
72	3	12	..... hrs. ..... min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business
FATHER 12. Name John Gruninger
13. Birthplace Philadelphia, Pa.
MOTHER 14. Maiden name Sylvania Goodwin
15. Birthplace Philadelphia, Pa.
16. Informant Registrar's Office, Clin. Records
Address Vets. Adm. Hosp., Ft. Howard, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov-12-46 (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Maryland
18. Funeral director John A. Moran
Address 3000 E. Balto. St., Balto., Md.
19. 11/11 1946 (Date rec'd by registrar) D. S. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8, 1946 at 7:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7, 1946, to November 8, 1946 and that I last saw him alive on November 8, 1946

Immediate cause of death	DURATION
Coronary Arteriosclerosis; Infarct of left ventricle	Unknown
Due to	
Due to	
Other conditions Thrombosis of pulmonary artery to lower lobe of left lung; Hydrothorax, left (Include pregnancy within 3 months of death)	Unknown "

Major findings of operations ..... Date of op. .....
Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE aor Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIRECTOR
Address V.A. Ft. Howard, Md. Date signed 11-8-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10775 P

Reg. Dist. No. 301

1. PLACE OF DEATH:
County: Baltimore
City or town: Westowne
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto
City or town: Westowne
(If outside city or town limits, write RURAL and give nearest town)
Street No. 201 Westowne Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Elias Hall

3.(b) Social Security Number: 217-14-3744

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Christiane R Hall
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): June 10 - 1892

8. AGE: Years	Months	Days	If less than one day
54	9	22	hrs. min.

9. Birthplace: Cecil Co Md
(Town, county, and state)
10. Usual occupation: Mariner
11. Industry or business: Tug boat
12. FATHER — Name: William H Hall
13. Birthplace: Virginia
14. MOTHER — Maiden name: Hafra Chamberlin
15. Birthplace: Cecil Co Md
16. Informant: Mr P. W. Hall
Address: 201 Westowne Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 5th 46 (month) (day) (year)
Cemetery or crematory: Galena Cemetery
Location: Galena Md
18. Funeral director: Charles F Powell
Address: 2427 E Edmondson Ave
19. Nov 4 1946 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 2, 1946, at 8.50 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20, 1946, to Nov. 2, 1946, and that I last saw him alive on October 31, 1946

Immediate cause of death	DURATION
Coronary Thrombosis + Myocardial	13 days
Due to: infarction	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Kenneth Gore Yaffe M. D. or other
Address: 3101 W Baltimore St Date signed: 11/4/46

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Yaffe

Dr ~~Yaser~~

3104 W Balto St

Phone Gi 1441

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1640)

CERTIFICATE OF DEATH

★

Reg. Dist. No. 33 10776 O

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

Church Road

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Church Road

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Franklin William Hanna

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife: Emma Winters Hanna

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): October 21 1871

8. AGE: Years 75 | Months - | Days 18 | If less than one day: ....hrs. ....min.

9. Birthplace: Reisterstown-Balto Co-Md (Town, county, and state)

10. Usual occupation: Carpenter - Retired

11. Industry or business: -

FATHER

12. Name: James Hanna

13. Birthplace: Unknown

MOTHER

14. Maiden name: Amanda Runk

15. Birthplace: Unknown

16. Informant: Albert Williams

Address: Reisterstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 12 1946 (month) (day) (year)

Cemetery or crematory: Asbury Cemetery

Location: Reisterstown Md

18. Funeral director: Wm Berryman & Sons

Address: Reisterstown Md

19. 11-11-1946 (Date rec'd by registrar) Mary B. Elins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 9 1946, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-44 1938, to 11-9 1946 and that I last saw h-im alive on 11-7 1946.

Immediate cause of death	DURATION
Gun Shot Wound of Throat	Instant.
& Head a Fractures of	
Due to: Mandible & Skull	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 11-9-1946

Where did injury occur? Reisterstown (City or town) Balto. (County) Md. (State)

Injured at home, farm, industry, public place (where?): At Home

Means of injury: Shot Gun, injured at work?

23. SIGNATURE: A. A. Caplis, M.D. (M. D. or other) Med. Exam

Address: Reisterstown, Md. Date signed: 11-10-46

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1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (79-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 1677 301

4

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Mrs. Carter's Nursing Home, 16 Fusting Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 Fusting Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma Hanssen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widow

6.(b) Name of husband or wife Late Frank Hanssen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1865

8. AGE: Years	Months	Days	If less than one day
80	11	13	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name William Adams
13. Birthplace Germany

MOTHER
14. Maiden name Mary -------
15. Birthplace Germany

16. Informant Albert L. Mehrling, (Nephew)
Address 4457 Morris St. Phila. 44, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 12/46. (month) (day) (year)
Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18. Funeral director Harry F. Mitzle
Address 4101 Edmondson Ave.

19. Nov. 12 1946 (Date rec'd by registrar) A. H. Hedrick Registrar

1-35 88

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10th 1946, at 6.45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946, to November 10 1946, and that I last saw h. alive on November 5th 1946.

Immediate cause of death	DURATION
Coronary Thrombosis	1/2 hour
Due to Arterio sclerotic type heart disease with hypertrophy + congestive failure	Years
Due to Generalized arterio sclerosis with Hypertension	Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Michel M. D. or other
Address Nov 11 1946 290 Edmondson Ave Baltimore Date signed

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-C)

CERTIFICATE OF DEATH

M778

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto.

City or town: Rural - Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

Garrison Forest Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: -

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3637 Malden Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Margaret Brown Harris

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	W.

6.(b) Name of husband or wife: Arthur Harris

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 21 1877

8. AGE: Years	Months	Days	If less than one day
69	2	21	..... hrs. ..... min.

9. Birthplace: Glyndon, Balto. Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

FATHER

12. Name: Samuel Brown

13. Birthplace: Unknown

MOTHER

14. Maiden name: "

15. Birthplace: "

16. Informant: Mrs. May Elizabeth Ducker

Address: 3637 Malden Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 15, 1946 (month) (day) (year)

Cemetery or crematory: Emory Chapel Cemetery

Location: Fowblesburg, Md.

18. Funeral director: Wm. Berryman & Sons

Address: Reisterstown, Md.

19. 11 - 13 - 19 46 (Date rec'd by registrar) Dr E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 12, 1946, at 4- A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5, 1946, to Nov. 12, 1946

and that I last saw her alive on Nov. 11. 1946

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to: Arterio Sclerosis	?
Due to:	
Due to:	
Other conditions: Chr. Nephritis	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. E. Nichols, Md

M. D. or other

Address: Pikesville-8, Md. Date signed: 11/13/46

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NOV 16 1946
BUREAU U. S.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

CERTIFICATE OF DEATH

10779 P

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years 7 months, 29days

Hospital, institution, or street address where death occurred: Spting Grove State Hospital

How long in hospital or institution? 4 years, 7 months, 29 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 5613 Bella vista Avenue (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Veronica Heil

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: -- - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 13, 1863

8. AGE: Years: 83 | Months: 9 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Fulda, Germany (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER 12. Name: John Heil

13. Birthplace: Germany

MOTHER 14. Maiden name: Cecilia Diegelman

15. Birthplace: Germany

16. Informant: Hospital records

Address: Catonsville, 28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-6-46 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore

18. Funeral director: Leonard J. Luck

Address: 5305 Harford Rd.

19. Nov. 5 1946 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 - 3 1946, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4, 1942 19.., to November 2 19 46 and that I last saw her alive on November 2, 1946 19..

Immediate cause of death	DURATION
Acute myocardial failure	4 days
Due to: Chronic hypertensive, arterio sclerotic cardiovascular dis.	Indefinit
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Henry C A Mead MD

Henry C. A. Mead, M.D., or other

Address: Catonsville, 28, Md. Date signed: 11/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

★ 16780

Reg. Dist. No. 44 /

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH

County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1307 Eastern Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary A. Herfel

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	married

6.(b) Name of husband or wife George Herfel Sr.

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) May 4th 1888

8. AGE: Years 58 | Months 6 | Days 3 | If less than one day ... hrs. ... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Louis C. Reis

13. Birthplace Md.

MOTHER 14. Maiden name Caroline Beh

15. Birthplace Pa.

16. Informant George Herfel Sr.

Address 1307 Eastern Ave. Essex

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 11-46 (month) (day) (year)

Cemetery or crematory Oak Lawn

Location Eastern Ave.

18. Funeral director John G. Connelly

Address 418 Eastern Ave. Essex

19. Nov. 11 1946 (Date rec'd by registrar) John G. Connelly (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7th 1946, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1-46 19.. to Nov 7 1946

and that I last saw h.. alive on Nov. 7-46 19..

Immediate cause of death	DURATION
~~Diabetes Mell.~~	
Coronary Occlusion	1
Due to Hyper Tension	
Due to Chronic Interstitial	
Other conditions Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Allen S. Burgham M. D. or other

Address 3139 E. Balto Date signed 11-10-46

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NOV 14 1946
BUREAU T.S.

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2
12

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-21)

CERTIFICATE OF DEATH

10781

Reg. Dist. No. 441

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk 7110 Martell Ave
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, institution, or street address where death occurred:
7110 Martell Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7110 Martell Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John Hess

3. (b) Social Security Number: 219019954

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Rebecca Hess
7. Birth date: March 20 1862 6.(c) If alive, give age: 67 years
Birth date of deceased (mo., day, yr.): March 20 1862

8. AGE:

Years	Months	Days	If less than one day
84	7	14	hrs. min.

9. Birthplace: Lowtemburg Germany (Town, county, and state)
10. Usual occupation: Store Keeper
11. Industry or business: Bethlehem Steel Co
FATHER 12. Name: Paul Hess
13. Birthplace: Germany
MOTHER 14. Maiden name: Marie
15. Birthplace: Germany
16. Informant: Rebecca Hess
Address: 7110 Martell Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/6/46 (month) (day) (year)
Cemetery or crematory: Mt. Carmel
Location: O'Donnell St.
18. Funeral director: John P. Connelly
Address: 418 Eastern Ave. Essex 21, Md.
19. 11/5/ 1946 John P. Connelly, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3 1946 at 7:00 AM

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from October 18 1946 to Nov 2 1946
and that I last saw him alive on Nov 2 1946

Immediate cause of death: Myocardial Insufficiency — DURATION: 1 wk
Due to: Hypostatic Pneumonia — DURATION: 2 days
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. V. Clift M.D.
Address: 5010 Greenleaf Road M. D. or other
Date signed: Nov 3-46

VS-A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-440

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10782

Reg. Dist. No. 440

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 600 W. Lexington St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: SAW

3.(a) FULL NAME: EARL W. HEWITT

3.(b) Social Security Number: 160-14-8707

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Tillie C. Hewitt
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): 2-20-77

8. AGE:

Years	Months	Days	If less than one day
69	8	24	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Earl C. Hewitt
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth MacMains
15. Birthplace: Maryland

16. Informant: Registrar's Office, Clinical Records
Address: Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/15/46 (month) (day) (year)

Cemetery or crematory: Private Cemetery
Location: Shipped to Phila., Pa., By Priv. Undertaker

16. Funeral director: Wm. Cook & Son
Address: St. Paul & Preston Sts., Balto., Md.

19. 11/15 (Date rec'd by registrar) 46 A. W. Roderick Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14, 1946, at 3:08 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6, 1946, to November 14, 1946 and that I last saw him alive on November 14, 1946

	DURATION
Immediate cause of death: Bronchopneumonia	2 Days
Due to:	Plus
Due to:	
Other conditions: Cerebral Thrombosis	8 Days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison, M.D. or other
R. M. CULLISON, M.D. CLIN. DIR.
Address: V. A., Ft. Howard, Md. Date signed 11-14-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

+ 10783

Reg. Diat. No. 320

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Villa Nova, Pikesville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Villa Nova, Pikesville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Essex Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Elizabeth Hoover

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Joseph Hoover

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1855

8. AGE: Years	Months	Days	If less than one day
90	10	25	..... hrs. ..... min.

9. Birthplace: Monkton, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Joshua Hicks

FATHER — 13. Birthplace: Monkton, Md.

MOTHER — 14. Maiden name: Sarah Tyson

MOTHER — 15. Birthplace: Monkton, Md.

16. Informant: Landon M. Brooks

Address: Sparks, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 24, 1946 (month) (day) (year)

Cemetery or crematory: Jessops

Location: Sparks, Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. 11/23/46 (Date rec'd by registrar) 19..... Dr E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 - 22 - 1946, at 3- P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Several years 19.. Nov. 22 - 19 46

and that I last saw her alive on Nov. 22, 19 46

Immediate cause of death	DURATION
Arterio Sclerosis	?
Due to	
Due to	
Other conditions: Senility	?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E E Nichols M.D. M. D. or other

Address: Pikesville, Md. Date signed 11-23-46

RECEIVED
NOV 26 1946
BUREAU U.S.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10784

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Baltimore
City or town: Randallstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Merrittesvilles Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Randallstown (If outside city or town limits, write RURAL and give nearest town)
Street No.: Merrittsvilles Rd. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME OSBORN IRVING PAUL HUMPLE

3. (b) Social Security Number NO

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: --
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 25, 1946

8. AGE: Years: | Months: 1 | Days: 9 | If less than one day ... hrs. ... min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual occupation: -
11. Industry or business

FATHER
12. Name: Walter R. Humple
13. Birthplace: Md.

MOTHER
14. Maiden name: Daisy L. Grimm
15. Birthplace: Va.

16. Informant: Mr. Walter R. Humple
Address: Merrittsvilles Rd., Randallstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/6/46 (month) (day) (year)
Cemetery or crematory: Mount Paran Presby. Cem.
Location: Mt. Paran, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 11-5-46 (Date rec'd by registrar) 19... A. W. Hedrick Registrar

1-35 ok

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4, 1946, at 5a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Suffocation	
Due to	
Due to: accident	
Other conditions: bed covers in crib over face	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Nov 4-46
Where did injury occur? Randallstown (City or town) Balto (County) Md (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: bed covers over face Injured at work?

23. SIGNATURE: [signature] Kieffer, Dep. Med. Exam. Balto Co. M. D. or other
Address: 1010 Leeds ave. Date signed: Nov 4 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Diat. No. 10787 281

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Balto.
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
La Paix Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. La Paix Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME HARRIET STERETT WINCHESTER JONES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife John Sparhawk Jones
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Dec. 18, 1858

8. AGE: Years	Months	Days	If less than one day
87	11	11	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Alexander Winchester
13. Birthplace Md.
MOTHER 14. Maiden name Sarah Carroll
15. Birthplace Md.
16. Informant Mrs. Bayard Turnbull
Address Rodgers Forge 4, Balto. Co., Md.
17. Cremation Date thereof 12/2/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenmount Cem.
Location Balto., Md.
18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.
19. 12-2 46 (Date rec'd by registrar) (19) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 19 46 at 10:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7 1946 to November 29 1946
and that I last saw her alive on November 29 1946

Immediate cause of death	DURATION
myocardial failure	1 month
Due to chronic myocarditis	several years
Due to arteriosclerosis	several years
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frankl R. Smith, Jr. M.D.
M. D. or other
Address 1014 St Paul St. Date signed 10/30/46.

Evidence for the change of date of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10786

FILM No. I 08 NOV 27 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:
County: Baltimore - 9.
City or town: Sparrows Point.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, institution, or street address where death occurred: 2505 Sycamore ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Dist #1.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: James Jones.

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Married

6.(b) Name of husband or wife: Annie Jones.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 1. 1871 or 72 - 1871

8. AGE: Years: 74. Months: Days: If less than one day: hrs. min.

9. Birthplace: Farmville. Va. (Town, county, and state)
10. Usual occupation: Farm hand.
11. Industry or business: on farm.
FATHER 12. Name: James Jones.
13. Birthplace: Va.
MOTHER 14. Maiden name: Julia (maiden name?)
15. Birthplace: Va
16. Informant: Annie Jones.
Address: above address.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-15-46 (month) (day) (year)
Cemetery or crematory: Mt. Calvary.
Location: A. A. Co.
18. Funeral director: Samuel W. Chase & Son
Address: 638 N. Gilmor St. - Balto.
19. 11-13 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12 19 46 at 12 50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 19 44 to Nov. 12 19 46.
and that I last saw h... alive on Oct. 6. 19 46.

Immediate cause of death	DURATION
myocardial degeneration	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis N. Collins M.D. M. D. or other
Address: Sparrows Point. Date signed 11/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

CERTIFICATE OF DEATH

★ 10787 Reg. Dist. No. 44

P

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County Maryland

City or town Fort Howard, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 62 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution? 62 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 702 N. Stricker St., Balto. Md. (If rural, give LOCATION)

2.(a) If veteran, name war WW I C.

3.(a) FULL NAME WILLIAM B. JONES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Lillian Jones

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 12-6-1881

8. AGE: Years	Months	Days	If less than one day
64	10	25	...hrs. ...min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Rigger

11. Industry or business

FATHER 12. Name Lorenzo Jones

13. Birthplace Wilmington, N.C.

MOTHER 14. Maiden name Julia Hudnew

15. Birthplace Virginia

16. Informant Registrar's Office, Clin. Records

Address Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-5-1946 (month) (day) (year)

Cemetery or crematory Balto. National Cemetery

Location Baltimore, Maryland

18. Funeral director Charles G. Cooper

Address 512 N. Carrollton Ave. Balto. Md.

19. Nov. 4 1946 G.W. Hebert Registrar

(Date rec'd by registrar)

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1946, at 1:15 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 31 1946, to November 1 1946 and that I last saw him alive on November 1 1946

Immediate cause of death	DURATION
Coronary Occlusion, acute	Sudden
Due to Heart disease, coronary arterio-sclerosis, myocardial damage,	unknown
Due to Cx anginal syndrome	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLIN. DIR.

Address VA., FORT HOWARD, MD. Date signed 11-1-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

10788 301
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Balto.
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred:
Harlem Lodge
How long in hospital or institution? 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 902 St. Paul St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Jacob M. Kahn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of ~~husband or~~ wife Bessie Kahn
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1858

8. AGE: Years	Months	Days	If less than one day
88	3	12	....hrs. ....min.

9. Birthplace Russia
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name Michael Kahn
13. Birthplace Russia
MOTHER 14. Maiden name Untermyer
15. Birthplace Russia
16. Informant Mr. Aaron J. Kahn
Address Stafford Hotel - Balto. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/2/46 (month) (day) (year)
Cemetery ~~or crematory~~ Baltimore Hebrew
Location Balto. Md.
18. Funeral director Arid Sondheim & Son
Address 1902 Eutaw Place - Balto. Md.
19. 12-2 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1946 at 6:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1946, to Nov 30 1946
and that I last saw h.i.m. alive on November 30 1946

Immediate cause of death	DURATION
CARDIAC FAILURE	
Due to SENILITY,	
ARTERIOSCLEROSIS	
Due to MYOCARDIAL INSUFFICIENCY	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. Williamson M.D.
M. D. or other
Address 3325 Frederick Ave Date signed 12/1/46

RECEIVED
DEC 2 1946
U.S. CAMP

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

10789 P

Reg. Dist. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1702 Abbottston Street
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Betty Eva Kees

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph Kees deceased

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 9, 1862

8. AGE: Years	Months	Days	If less than one day
84	3	5	hrs. min.

9. Birthplace: Frederick, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Fred Schmidt
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Karckhoff
15. Birthplace: Germany

16. Informant: Hospital Records,
Address: Catonsville, 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/18/46 (month) (day) (year)

Cemetery or crematory: London Park

Location: Baltimore, Md.

18. Funeral director: Mahoney & Son

Address: 1214 E. Pond St.

19. 11-15-46 (Date rec'd by registrar) 19 Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14 19 46 at 3:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31 19 46, to November 14 19 46 and that I last saw h er alive on November 14, 1946 19

Immediate cause of death	DURATION
Terminal broncho - pneumonia, left base -	3 days
Due to: Chronic arteriosclerotic C-V disease	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None held

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M. D.
M. D. or other

Address: Catonsville, 28, Md. Date signed: 11/14/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

10790

Reg. Dist. No. 301

1. PLACE OF DEATH:

County: Balto.

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred:
5501 Edmondson Ave. - Hood Nurs. Ho

How long in hospital or institution? Since Aug. 14th, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: aa

City or town: Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Carroll & Church Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SOPHIA A. KING

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Harry S. King

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 27, 1870

8. AGE: Years	Months	Days	If less than one day
75	10	8	..... hrs. ..... min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: John Andreas
13. Birthplace: Germany

MOTHER
14. Maiden name: - Kern
15. Birthplace: Germany

16. Informant: Mrs. Eleanor J. Elder - daughter
Address: Carroll & Church Rds., Riveria Beach, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/7/46 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 11/7 '46 (Date rec'd by registrar) Adam Hedrick Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 5, 1946, at 11:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Nov 5 1946 and that I last saw h... alive on Nov 5 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 Day
Due to: Arterio Sclerosis	
Due to:	
Other conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: [illegible] M. D. or other

Address: Catonsville Date signed 11/6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-a

CERTIFICATE OF DEATH

★ 10791

Reg. Dist. No. 410

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8227 Dundalk Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Louisa E. Knight

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widow

6.(b) Name of husband or wife: James Knight

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 28, 1881

8. AGE: Years	Months	Days	If less than one day
64	11	1	..... hrs. ..... min.

9. Birthplace: Wales (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Richard Williams

13. Birthplace: Wales

MOTHER — 14. Maiden name: Louisa Beacham

15. Birthplace: Wales

16. Informant: Mrs. Otto Laudien

Address: 8227 Dundalk Ave., Dundalk

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov. 29, 1946 (month) (day) (year)

Cemetery or crematory: Nanticoke

Location: Nanticoke, Penna.

18. Funeral director: Roland L. Fisher

Address: 2112 Dundalk Ave.

19. 11-29-46 (Date rec'd by registrar) J. M. Learmonth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29, 1946, at 3:30 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 22, 1946, to Nov 27, 1946

and that I last saw h... alive on Nov 27, 1946

Immediate cause of death	DURATION
(a) Hypertension	
(b) Cerebral apoplexy	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. M. Learmonth MD M. D. or other

Address: 3400 E. Belvedere Date signed 11/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 9 1946
BUREAU V S.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

CERTIFICATE OF DEATH

★ 10792

Reg. Diat. No. 372

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

1. PLACE OF DEATH:
County Baltimore
City or town Cockeysville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
Masonic Home, Cockeysville, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Baltimore Highlands
(If outside city or town limits, write RURAL and give nearest town)
Street No. Vermont Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Paul Kraushaar

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Elizabeth Kraushaar
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 - 1864

8. AGE: Years	Months	Days	If less than one day
82	5	17	hrs. min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Blacksmith
11. Industry or business
FATHER 12. Name John Kraushaar
13. Birthplace Germany
MOTHER 14. Maiden name Magdelina Yeager
15. Birthplace Germany
16. Informant Laura M. Schroeder
Address Masonic Home, Cockeysville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 27-46 (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Baltimore Md.
18. Funeral director Wm. Cook
Address St. Paul & Preston St
19. Nov 25 19 46 (Date rec'd by registrar) Laura M. Schroeder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 19 46, at 10 25 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 19 46, to Nov 24 19 46
and that I last saw him alive on Nov. 24 19 46

Immediate cause of death	DURATION
Acute Congestive Failure	
Cardiac	3 days
Due to	
Arteric Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter J. Kuss M. D. or other
Address Cockeysville, Md Date signed 11/24/46

RECEIVED
NOV 26 1946
BUREAU V.S.

1 - 25

2 - 370 - 1 - 10

R.C. Hudson Towson 32

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-H)

CERTIFICATE OF DEATH

Reg. Dist. No. 10793 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Parkville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 3017 Acton Road
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 18 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Parkville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3017 Acton Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Helen Mar Krebs

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Joseph H. Krebs deceased 6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 72 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Beverly McNeil
13. Birthplace Md.

MOTHER 14. Maiden name ?
15. Birthplace ?

16. Informant Joseph W. Krebs Jr.
Address 3017 Acton Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/27/46 (month) (day) (year)
Cemetery or crematory Dulaney
Location Balto. Co.

18. Funeral director C. J. Fanning & Son
Address 1938 E. Lafayette Ave.

19. 11-25 46 (Date rec'd by registrar) Registrar

1-25 2-3 20-1-10

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1946 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19__ to ____ 19__, and that I last saw h__ alive on ____ 19__

Immediate cause of death Carbon monoxide poisoning - Suicide — DURATION 11/23/46

Due to ____

Due to ____

Other conditions ____

(Include pregnancy within 3 months of death)

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of Nov. 23, 1946.
Where did injury occur? Parkville (City or town) Baltimore (County) Md. (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury Carbon monoxide-gas stove Injured at work?

23. SIGNATURE Rollin E. Hudson MD RME (M. D. or other)
Address Towson Md Date signed 11/27/46

Correction of Name:
Bapt. record filmed
6110 6-17-47
Bureau Vital Statistics
LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176)

CERTIFICATE OF DEATH

10794 P

Reg. Dist. No. 440

1. PLACE OF DEATH:
County: Balto.
City or town: Sparrows Pt.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Rural near Ft Howard
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Todd Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: 2

3.(a) FULL NAME: Stanley Joseph Krol
3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mildred Krol
6.(c) If alive, give age: 25 years
7. Birth date of deceased (mo., day, yr.): Dec 28 1916

8. AGE: Years: 29 | Months | Days | If less than one day: hrs. min.

9. Birthplace: New Castle Pa
(Town, county, and state)
10. Usual occupation: Steel Worker
11. Industry or business: Bethlehem Steel
FATHER 12. Name: Jos Krol
13. Birthplace: Poland
MOTHER 14. Maiden name: Antonia Zamecka
15. Birthplace: Poland
16. Informant: Mildred Krol
Address: Todd Ave Ft Howard.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 8th (month) (day) (year)
Cemetery or crematory: Balto National Cem
Location: Rural
18. Funeral director: Ullrich Funeral Home
Address: 2008 Aliceanna St
19. Nov. 6 1946 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOV. 5 1946 at 10 V A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
1. LACERATION, Rt thigh & severing	
Femoral Artery 2. Traumatic	
Due to Amputation Rt. Arm -	
3 Contusion Rt. Side Chest	
Due to 4. Probable Internal Injuries	
Other conditions	

(Includes pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 11-5-46
Where did injury occur? Beth Steel Co. Sp. Pt. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Industry
Means of injury: Caught between Rolls + Plate Injured at work? Yes.

23. SIGNATURE: W B Davis M.D.
Dept. Med. Examiner Balto. M. D. or other
Address: Ft Howard Md. Date signed: 11-5-46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 16705 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Middleborough (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Elk Rd.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 2 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegheny
City or town Near Old Town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harry N Lamm

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18 - 1888

8. AGE: Years	Months	Days	If less than one day
58	5	~~24~~ 6	hrs. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name George Lamm
FATHER 13. Birthplace ?
MOTHER 14. Maiden name Christine Elfing
MOTHER 15. Birthplace Baltimore
16. Informant Mrs. Eleanor Abercrombie
Address Elk Rd. Middleborough
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 27-46 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Belair Rd.
18. Funeral director Elizabeth Hartle Sons.
Address 115 E. West St.
19. 11/26/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946, to Nov 23 1946, and that I last saw h alive on Nov 24 1946.

Immediate cause of death	DURATION
Coronary Thrombosis	4 mos.
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thomas B Hanley M.D.
M.D. or other
Address 814 Eastern Ave Date signed 11/27/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10796 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore County.
City or town Catonsville.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days.
Hospital, institution, or street address where death occurred:
550 Edmondson Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County —
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1838 W. Fayette St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sallie M. Le Compte.

3.(b) Social Security Number: none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: Samuel E. Le Compte.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 14th 1866.

8. AGE: Years	Months	Days	If less than one day
80.	6.	2.	..... hrs. ..... min.

9. Birthplace: Dorchester Co. - Md.
(Town, county, and state)
10. Usual occupation: House Wife.
11. Industry or business —

FATHER
12. Name: Unknown.
13. Birthplace: Md.

MOTHER
14. Maiden name: Unknown.
15. Birthplace: Md.

16. Informant: Mrs. Ruth M. Bading.
Address: 1838 W. Fayette St.

17. Burial. Date thereof Nov. 19 - 1946.
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery.
Location: Woodlawn - Md.

18. Funeral director: Charles J. Schwab.
Address: 505 N. Monroe St.

19. 11-19 1946
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16 1946, at 11-45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 6 1946 to Nov 16 1946 and that I last saw h... alive on Nov 16 — 1946

Immediate cause of death	DURATION
Chronic Myocarditis.	2 yrs
Due to Arteriosclerosis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Catonsville Md. Date signed 11-17-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73d)

CERTIFICATE OF DEATH

10797

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 7 mos., 1 day
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 3 years, 7 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 108 Rochester Place
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Matilda Leipelt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Edward Leipelt
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 8, 1861

8. AGE:

Years	Months	Days	If less than one day
85	9	14	hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Factory worker
11. Industry or business: Factory
12. FATHER — Name: Peter Ricker
13. FATHER — Birthplace: Germany
14. MOTHER — Maiden name: Barbara Hensler
15. MOTHER — Birthplace: Germany
16. Informant: Hospital records
Address: Catonsville-28, Maryland
17. Burial (Burial, cremation, or removal. What?) Date thereof 11/25/46 (month) (day) (year)
Cemetery or crematory: Edmonds
Location: Donnell Rd.
18. Funeral director: Jno. J. Ahern
Address: 3000 E. Balto. St.
19. 11/23 (Date rec'd by registrar) 1946 Harry W. Miller Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22 1946, at 3:45 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21 1943, to November 22 1946 and that I last saw her alive on November 22 1946

	DURATION
Immediate cause of death: Arteriosclerotic gangrene, right leg	40 hrs.
Due to: Arteriosclerotic cardiovascular disease	indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other
Address: Catonsville-28, Md. Date signed: 11-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

RECEIVED
NOV 25 1946
1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10798 8

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:
County Baltimore
City or town Reisterstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Mt. Pleasant
Stay in hospital or inst. (yrs., or mos., or days) 6 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 2011 Presbury Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Harriet Levine

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1928

8. AGE: Years	Months	Days	If less than one day
18	4	11	hrs. min.

9. Birthplace Baltimore - Md
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Abraham Levine
13. Birthplace Russia

MOTHER
14. Maiden name Lillian Witton
15. Birthplace Russia

16. Informant Lillian Levine (mother)
Address 2011 Presbury Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-15-46 (month) (day) (year)
Cemetery or crematory Shaarei Tfiloh Cem
Location Wyndon Md Rd

18. Funeral director Jack Levin Inc
Address 1439 E. Balto St.

19. 11/14 (Date rec'd by registrar) 19 46 A. G. Hedrick Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1946 at 5 20 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 8, 1946, to Nov. 14, 1946
and that I last saw h[illegible] alive on Nov. 14, 1946

Immediate cause of death	DURATION
Myocardial Failure	
Due to Pulmonary Tuberculosis	18 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Albert J. Shrier MD M. D. or other
Address Reisterstown, Md Date signed 11/14/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

★ 10799 P

Reg. Dist. No. 44-0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING (I)

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: 607 J Street Spanish P
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Sparrows Point Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 607 J Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Sylvester Long

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

8.(b) Name of husband or wife: Elizabeth Long
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 30, 1912

8. AGE: Years	Months	Days	If less than one day
34			..... hrs. ..... min.

9. Birthplace: S. Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: Andrew Long
13. Birthplace: S. C.

MOTHER
14. Maiden name: Bertha Hall
15. Birthplace: S. C.

16. Informant: Elizabeth Long
Address: 609 J. St.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov 8 46 (month) (day) (year)

Cemetery or crematory:
Location: Chester S Carolina

18. Funeral director: Mrs. Lott & Edwards Daughter
Address: 1129 N. Caroline St.

19. 11/7 (Date rec'd by registrar) 1946 A. W. Hedrick (Registrar)

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6th 1946, at 10:45 A.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from April 1946, 19..., to Nov 6th, 1946, 19...; and that I last saw him alive on November 6th 1946.

Immediate cause of death: Lobar Pneumonia bilateral — DURATION: 3 Days
Due to: Osteomyelitis — Indefinite
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. H. Thomas M.D.
M. D. or other
Address: Sunnieista, Md Date signed: 11/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

16800 8

Reg. Dist. No. 320

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkville 2907 Hill Crest Ave.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Parkville 2907 Hill Crest Ave.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: WILLIAM D. LONG

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Hettie Long 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): October 9, 1862

8. AGE: Years	Months	Days	If less than one day
84	1	8	...hrs. ...min.

9. Birthplace: Howard Co. Md. (Town, county, and state)

10. Usual occupation: Retired Machinist

11. Industry or business: Penna. R. R. Co.

FATHER 12. Name: William L. Long

FATHER 13. Birthplace: Md.

MOTHER 14. Maiden name: Ann Rebecca Orem

MOTHER 15. Birthplace: Md.

16. Informant: Mr. Roy P. Long (Son)

Address: 2907 Hill Crest Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/30/46 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cemetery

Location: Pikesville Md.

19. Funeral director: WM. J. TICKNER & SONS INC.

Address: North & Pa Aves Balto. 17, Md.

19. 11/29/1946 (Date received by registrar) G W. Heckrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27, 1946 at 4:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 1946, to Nov. 27th 1946 and that I last saw h... alive on Nov. 26th 1946.

Immediate cause of death	DURATION
Exhaustion	
Due to Carcinoma Jaw and oral cavity.	20yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Geo. DeCross M. D. or other

Address: 28 W 25th St Date signed 11-28-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (118-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 10801 44

1. PLACE OF DEATH:
County Baltimore
City or town Sparrows Pt. —
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Baltimore.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1033 N. Caroline St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Lyons.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Black	Married.

6.(b) Name of husband or wife Pauline
8.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 22, 1907

8. AGE: Years	Months	Days	If less than one day
39			hrs. min.

9. Birthplace M. Carolina (Town, county, and state)
10. Usual occupation Steel Worker
11. Industry or business

FATHER
12. Name Charles A. Lyons
13. Birthplace N.C.

MOTHER
14. Maiden name Maggie Higgins
15. Birthplace N.C.

16. Informant Pauline Lyons
Address 1033 N. Caroline St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 15, 1946 (month) (day) (year)
Cemetery or crematory Mt. Calvary Cem
Location A A County Md.

18. Funeral director Mrs. Pott A. Elliott Daughty
Address 1129 N. Caroline St

19. Nov 12, 1946 (Date rec'd by registrar) A. St. Heacock Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11-46, 1946, at 12 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h ..... alive on ..... 19.....

	DURATION
Immediate cause of death Carbon Monoxide Poisoning	
Due to Inhalation of Blast Furnace Gas	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 11-11-46
Where did injury occur? Sp. Pt. (City or town) Balto. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Industry
Means of injury Inhaled Blast Furnace Gas Injured at work? Yes

23. SIGNATURE M. Bowers M.D. M. D. or other
Address Dispensary Sparrows Pt. Date signed 11/11/46

VS-A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 10802 Reg. Dist. No. 371

2

1. PLACE OF DEATH:

County: Baltimore

City or town: Sparks (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sparks (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: York Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: John Craig Martin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Widowed

6.(b) Name of ~~husband~~ or wife: Helen (nee Arnold)

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 12 1864

8. AGE:

Years	Months	Days	If less than one day
82	6	19	..... hrs. ..... min.

9. Birthplace: New York City

(Town, county, and state)

10. Usual occupation: Insurance (Retired 15 Yrs)

11. Industry or business

FATHER

12. Name: Samuel Martin

13. Birthplace: N. Y. City.

MOTHER

14. Maiden name: Gertrude Craig

15. Birthplace: N. Y. City.

16. Informant: Mrs. J. Frank Lupo

Address: Sparks, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-4-46 (month) (day) (year)

Cemetery or crematory: Hillside

Location: Metuchen, N. J.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. Nov. 1 1946 Wm. J. Whitcomb

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 1946, at 5 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 31 1946, to November 1 1946

and that I last saw h... alive on October 31 1946

Immediate cause of death: Chronic nephrosclerosis — DURATION:

Due to:

Due to:

Other conditions: generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Elizabeth B. Sherrill M.D.

M. D. or other

Address: Cockeysville, Md. Date signed: Nov. 1, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 5 1946

1-25

2-370

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1080381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4502 Ochenley Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lola Elizabeth Mattison

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married.

6.(b) Name of husband or wife: Arthur C. Mattison
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): Dec 19, 1922

8. AGE:

Years	Months	Days	If less than one day
23	10	21	hrs. min.

9. Birthplace: St. Mary's Co Mo
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: own home

FATHER
12. Name: Joseph Perry
13. Birthplace: St. Mary's Co Mo

MOTHER
14. Maiden name: Lola Johnson
15. Birthplace: St Mary's Mo.

16. Informant: Personal History- Hospital Records
Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 14th 1946 (month) (day) (year)
Cemetery or crematory: Mt Olive Cemetery
Location:
18. Funeral director: Charles P Towell
Address: 2427 E. Monument Ave

19. 11-13 1946 (Date rec'd by registrar) Registrar

T-25-520-10

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11 1946, at 2-40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 9 1946 to Nov 11 1946
and that I last saw h[illegible] alive on Nov 11 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W G Budgen M. D. or other
Address: Towson 4, Maryland Date signed: 11/11/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4-28

1C804

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Baltimore
City or town: Landsdowne
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred:
210 Minebank Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Gluey
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henry J. McAllister

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife: late Fannie McAllister
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 20, 1858

8. AGE:

Years	Months	Days	If less than one day
88	-	6	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: — McAllister
13. Birthplace: Virginia

MOTHER
14. Maiden name
15. Birthplace: Virginia

16. Informant: Mr. R. C. Thurston
Address: 210 Minebank Lane

17. Burial - Removal (Burial, cremation, or removal. Which?) Date thereof 11. 29. 46 (month) (day) (year)
Cemetery or crematory: Mt Mora
Location: White Hall Virginia
18. Funeral director: Harry H. Witzke
Address: 4101 Edmondson Ave

19. 11/26 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26th 1946 at 5A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18th 1946 to Nov. 26 1946 and that I last saw him alive on Nov. 24th 1946

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Chronic Myocarditis	
Due to: Arteriosclerotic Heart disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. E. Patterson M.D.
Address: Landsdowne Md. M. D. or other
Date signed: 11/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 20 — 10805

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Opitz Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland — County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1113 Ellicott Drive.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: RIVAS LEE McDONALD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah Thomas McDonald — 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 29 th. March 1873

8. AGE: Years	Months	Days	If less than one day
73	7	5	hrs. min.

9. Birthplace: Richmond Va. (Town, county, and state)
10. Usual occupation: ----
11. Industry or business

FATHER — 12. Name: John W. McDonald
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Lucy F. Ellis
15. Birthplace: Virginia

16. Informant: Mrs. Sarah T. McDonald
Address: 1113 Ellicott Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6 Nov. 46 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore Maryland

18. Funeral director: F. B. Wippert & Son
F.B.WIPPERT & SON
Address: 1300 Eutaw Place, Balto. 17

19. 11-5 (Date rec'd by registrar) 1946 A W Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3rd. 1946, at 10.C. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 1946, to Nov 3 1946
and that I last saw h. 1m alive on nov. 3- 1946

Immediate cause of death	DURATION
Coronary Occlusion	Brief.
Due to Chronic Myocarditis	6mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Thos H Shiller M.D. M. D. or other.
Address: 1939 Edmondson Ave. Date signed 11/4/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-a)

CERTIFICATE OF DEATH

16806

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Balto

City or town Dundalk

(If outside city or towe limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6815 Holabird Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ANNA MENNIT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Defant.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 29 - 1946

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 0 hrs. 55 min.

9. Birthplace Dundalk-Vt Md (Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER 12. Name John MENNIT

FATHER 13. Birthplace W. Va.

MOTHER 14. Maiden name BERTHA WILLS

MOTHER 15. Birthplace DUNDALK, VT MD

16. Informant John Mennit

Address 6815 Holabird

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 30/46 (month) (day) (year)

Cemetery or crematory Mt Carmel

Locatico Balto Md

18. Funeral director Welsh Funeral Home

Address 2008 Orleans St

19. 11/30 1946 A. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1946 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Atelectasis	40 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or towe) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M Bravo M.D. M. D. or other

Address Dundalk Vt Date signed 11/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-d)

CERTIFICATE OF DEATH

16807

Reg. Dist. No. 381

1. PLACE OF DEATH
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 weeks (Home-Lutherville)
Hospital, Institution, or street address where death occurred:
20 W. Chesapeake Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Lutherville
(If outside city or town limits, write RURAL and give nearest town)
Street No. College Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ella Mitchell

3.(b) Social Security Number *******

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William Henry Mitchell

6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) December 28, 1875

8. AGE: Years	Months	Days	If less than one day
70	10	18	....hrs. ....min.

9. Birthplace Kingston, Pennsylvania (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name Jonah Mayo
13. Birthplace England

MOTHER
14. Maiden name Anne Burden
15. Birthplace England

16. Informant Mrs. Byron Bishop
Address College Avenue, Lutherville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof November 18, 1946 (month) (day) (year)
Cemetery or crematory Prospect Hill Cemetery
Location Towson, Maryland

18. Funeral director John Burns' Sons
Address Towson, Maryland

19. 11 18 1946 (Date rec'd by registrar) H. Carroll Gaston Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1946, at 11:47 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19..., to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Heart disease, Chronic with Coronary occlusion	1 day
Due to Chronic myocarditis, with decompensation	Unk. yrs. approx.
Due to Arteriosclerosis	Unk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Rollin C. Hudson M.D. DME
M. D. or other
Address Towson, Md. Date signed 11/16/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

NOV 30 1945
BUREAU OF

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2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16808 P

Reg. Dist. No. 440

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 179 days
Hospital, institution, or street address where death occurred:
Veterans Adms., Fort Howard, Maryland
How long in hospital or institution? 179 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: North Carolina County:
City or town: Princeton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME
WILLIAM R. MOORE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2/23/22

8. AGE: Years	Months	Days	If less than one day
24	8	17	..... hrs. ..... min.

9. Birthplace: North Carolina
(Town, county, and state)
10. Usual occupation: Student
11. Industry or business

FATHER
12. Name: Deceased
13. Birthplace

MOTHER
14. Maiden name: Julia R. Moore
15. Birthplace: Unknown

16. Informant: Clinical Records
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-15-46 (month) (day) (year)
Cemetery or crematory: Goldsboro
Location: North Carolina
18. Funeral director: Charles L. Law
Address: 802 Madison Avenue

19. Nov. 12 1946 A. H. Pickrell Registrar
(Date rec'd by registrar)

1-35 P

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10 19 46, at 3:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/15/46 19 to 11/10/46 19
and that I last saw him alive on November 10 19 46

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS, FAR ADVANCED	7 months
Due to	plus
Due to	
Other conditions ABSCESS, LT. FEMORAL TRIANGLE	7 mths
ARTHRITIS, TUBERCULOUS, BOTH HIP JOINTS & SACROILIAC	7 mths.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison
R.M. CULLISON, M.D. Clin. M.D. or other
Address V.A.H. Ft. Howard, Md. Date signed 11/11/46

VS-A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-0)

CERTIFICATE OF DEATH

★ 10809

Reg. Dist. No. 301

1. PLACE OF DEATH:
County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 year, 21 days
Hospital, institution, or street address where death occurred: Spring Grove Hosp
How long in hospital or institution? 11 years, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Balto
(If outside city or town limits, write RURAL and give nearest town)
Street No. 203 North Monastery Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary a Munson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	white	widowed

6.(b) Name of husband or wife: — Mundon
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): March 1, 1867

8. AGE: Years	Months	Days	If less than one day
79	8	2	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home

FATHER
12. Name: Cornelius Sheehan
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ellen Long
15. Birthplace: ?

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/8/46 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. 11-4-46 (Date rec'd by registrar) Harry L. Mueller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3 46, at 10-25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Terminal Bronchopneumonia	
Due to Cardio Vascular Renal Disease	
Due to Fracture right femur	
Other conditions Sudden death Surgery	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Oct 31 46
Where did injury occur? Catonsville Balto md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Hospital
Means of injury Pushed by another patient Injured at work? no

23. SIGNATURE: G. McLiefter Asst Med Exam Balto
M. D. or other
Address: 1010 Leadenhall Date signed: Nov 4-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 6 1946
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Evidence for additions made shown on

10810

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

CERTIFICATE OF DEATH

FILE No. 10.8 NOV 26 1946

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Fort Howard Veterans Hospital, Fort Howard, Md

How long in hospital or institution? Oct. 15/46 to Nov. 23/46

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Dundalk (If outside city or town limits, write RURAL and give nearest town)

Street No. 2664 2664 Cornwall Road Balto. 22, Md. (If rural, give LOCATION)

2.(a) If veteran, name war World War II (S)

3.(a) FULL NAME GEORGE L. MURA

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	Married

6.(b) Name of husband or wife Ann Mura

6.(c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) April 19, 1917

8. AGE: Years 29 Months 7 Days 4 If less than one day ..... hrs. ..... min.

9. Birthplace Morann, Pennsylvania (Town, county, and state)

10. Usual occupation Student-Vocation School

11. Industry or business

FATHER 12. Name George Mura

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Mary Plasko

15. Birthplace Pennsylvania

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 27-1946 (month) (day) (year)

Cemetery or crematory Routzdale

Location Routzdale Pennsylvania

Oder Funeral Home

18. Funeral director Ellsworth Brothers

4644 York Rd. Balto. Md.

Address 3914 Liberty Hghts Ave. Balto Md

19. 11-24 1946 Harry L. Mullin Deputy Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1946, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 1946, to Nov. 23, 1946 and that I last saw him alive on November 23, 1946

Immediate cause of death	DURATION
Chronic glomerular nephritis	1-5 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison

R. M. CULLISON, M.D. CLIN. DIR.

M. D. or other

Address V. A. Ft. Howard, Md. Date signed 11-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

RECEIVED
NOV 26 1946
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1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(167) + 10811

CERTIFICATE OF DEATH

Reg. Dist. No. 38 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County BALTIMORE

City or town TOWSON

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

SHEPPARD AND ENOCH PRATT HOSPITAL

How long in hospital or institution? Since June 24, 1942

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1019 Woodside Parkway

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MURPHY, Mrs. Mary Cooley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Edward Murphy

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 6, 1870

8. AGE: Years	Months	Days	If less than one day
76	4	22	..... hrs. ..... min.

9. Birthplace New York City, N.Y. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Martin Cooley

13. Birthplace Ireland

MOTHER 14. Maiden name Catherine Brady

15. Birthplace Ireland

16. Informant HOSPITAL RECORDS

Address

17. Removal & Burial (Burial, cremation, or removal. Which?) Date thereof 12/4/46 (month) (day) (year)

Cemetery or crematory Cathedral

Location Savannah, Chatham Co. Ga.

18. Funeral director W. Harner E. Humphrey.

Address Silver Spring, Md.

19. 12/6 19 46 A. M. Bacon. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 19 46 at 7:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/3/46 19 ..... to ..... 19 .....

and that I last saw her alive on November 28 19 46

Immediate cause of death	Duration
Bronchopneumonia	10 days
Due to	
Due to	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Bi-lateral bronchopneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry M. Murdock Harry M. Murdock, M. D. M. D. or other

Address TOWSON, MARYLAND Date signed 11/29/46

RECEIVED

DEC 6 1948

BALTIMORE COUNTY
HEALTH DEPARTMENT

1-35-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 10810 X 0

8

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 392 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution? 392 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Baltimore County:

City or town: Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1032 Ensor Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2 (S)

3. (a) FULL NAME: JOHN P. MURRAY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4-15-1903

8. AGE:	Years	Months	Days	If less than one day
	43	6	28	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Produce Business

11. Industry or business:

MOTHER FATHER

12. Name: John P. Murray

13. Birthplace: Maryland

14. Maiden name: Marie Gavin

15. Birthplace: Ireland

16. Informant: Registrar's Office, Clin. Records

Address: Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 16, 1946 (month) (day) (year)

Cemetery or crematory: New Cathedral Cemetery

Location: Baltimore, Maryland

18. Funeral director: Elmer W. Conklin

Address: 924 E. Eager St., Balto., Md.

19. 11-14 46 (Date rec'd by registrar) Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13, 1946, at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 17, 1945, to November 13, 1946 and that I last saw him alive on November 13, 1946

Immediate cause of death	DURATION
Diffuse cerebral Atrophy and sclerosis of occipital lobe of brain, cause undetermined.	2 yrs.
Due to:	
Due to:	
Other conditions: Disease of the Heart: cause Rheumatism, structural lesion-Mitral valvulitis. Manifestation- none	2 yrs.

Major findings of operations:

Date of op.:

Autopsy results: Confirming the above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. E. Pugh, M.D.

Address: VA. Ft. Howard, Md. M. D. or other

Date signed: 11-13-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

10813 P

CERTIFICATE OF DEATH

Reg. Dist. No. 440

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1608 N. Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war: SAW

3.(a) FULL NAME: THOMAS JOSEPH NAPFEL

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Deceased Margaret
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 27, 1876

8. AGE: Years	Months	Days	If less than one day
70	4	29	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: unemployed
11. Industry or business

FATHER
12. Name: Edward M. Napfel (dec.)
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Christina Koesener (dec.)
15. Birthplace: Baltimore, Maryland

16. Informant: Clin. Rec. Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 30-1946 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Balto Md
18. Funeral director: Pott & Co & B.M. Walters
Address: Pratt & Stricker Sts

19. 11/29 1946 A W Hedrick (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26 19 46, at 9:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21 19 46 to November 26 19 46 and that I last saw him alive on November 26 19 46

Immediate cause of death	DURATION
Uremia	11 Mos.
Due to: Nephrosclerosis	plus Same
Due to:	
Other conditions: Disease of the Heart, Cause: Hypertension & Arteriosclerosis, S.I.: Cardiac enlargement, myocardial damage Manif: Myocardial Insufficiency	Same

(Include pregnancy within 3 months of death)
Operation for: Arteriosclerosis, general
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR.
M. D. or other
Address: VAH FT. HOWARD, MD. Date signed 11-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10814

CERTIFICATE OF DEATH

Reg. Diat. No. 301

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
36 N Prospect Ave
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 36 N Prospect Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles W Neal

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

8.(b) Name of husband or wife Frances A Neal
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 3 1871

8. AGE: Years 75 | Months 1 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Fisherman
11. Industry or business
12. FATHER Name George Neal
13. FATHER Birthplace Va
14. MOTHER Maiden name Mollie E Williams
15. MOTHER Birthplace Va
16. Informant Mrs Frances A Neal
Address 36 N Prospect Ave
17. Burial Date thereof Nov 27 46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Woodland Cemetery
Location Fredericksburg Va
18. Funeral director George A Staley
Address Catonsville Md
19. 11-23-1946 Harry W Mueller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1946, at 7:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1946 to Nov 22 1946
and that I last saw h... alive on Nov 21 1946

Immediate cause of death	DURATION
Cerebral Hemmorrage	12 hrs.
Due to Artero-Sclerotic Heart Disease	6 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George Elliston M. D. or other
Address Catonsville 28 Md Date signed Nov 22 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 25 1946

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10815

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or Town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years, 19 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 14 years, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 343 South Stricker Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: David Nickey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Jennie Nickey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 14, 1885

8. AGE:

Years	Months	Days	If less than one day
61	10	12	hrs. min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Furniture finisher

11. Industry or business: Self

FATHER
12. Name: Samuel Nickey
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Mary Utz
15. Birthplace: Pennsylvania

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 29-1946 (month) (day) (year)
Cemetery or crematory: Meadow Branch Cem
Location: W Westminster Md.

18. Funeral director: Geo K. Beyer Jr
Address: 15 12 Hollins St Balto 23 Md

19. 11/29 19 46 (Date rec'd by registrar) G W Speddich Registrar
1-35 J.C

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26 19 46, at 10:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7 19 32, to November 26 19 46 and that I last saw h. im alive on November 26 19 46

Immediate cause of death	DURATION
Chronic myocardial insufficiency	indef.
Due to: General paresis, syphilis	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other
Address: Catonsville--28, Md. Date signed: 11-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-0)

CERTIFICATE OF DEATH

10816

Reg. Dist. No. 420

1. PLACE OF DEATH:
County: Baltimore Co.
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 4307 Kensington Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4307 Kensington Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Elmer A. Noon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Amos Noon
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 26 1906

8. AGE: Years	Months	Days	If less than one day
40	5	25	hrs. min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual occupation: Policeman
11. Industry or business: Baltimore City
12. Name of father: Michael Noon
13. Birthplace of father: Baltimore Md.
14. Maiden name of mother: Elizabeth Cunningham
15. Birthplace of mother: Baltimore Md.
16. Informant: Mrs Elizabeth A. Noon
Address: 4307 Kensington Road.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-23-1946 (month) (day) (year)
Cemetery or crematory: Cathedral Cemetery
Location: Baltimore Md.
18. Funeral director: Flynn & Fleming
Address: 1426 Light St.
19. Nov 22 1946 (Date rec'd by registrar) G. W. Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 1946 at 6P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	Sudden Death
Other conditions	Fainting

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.: .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: G. W. Kieffer Dep Med Exam Balto
M. D. or other
Address: 1010 Leadenhall Date signed: Nov 22 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 25 1946

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

10817

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1211 Cathedral St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MARCIA CROCKER NOYES

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 29, 1869

8. AGE: Years: 76 | Months: 10 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: Saratoga New York
(Town, county, and state)

10. Usual occupation: Librarian

11. Industry or business: Med. Chirurgical Faculty Md

FATHER
12. Name: Lewis S. Noyes
13. Birthplace: New York

MOTHER
14. Maiden name: Catherine Crocker
15. Birthplace: New York

16. Informant: Personal History- Hospital Records

Address: Eudowood Sanatorium, Towson 4, Md.

17. (Burial, cremation, or removal. Which?) Cremation Date thereof: 11/27/46 (month) (day) (year)

Cemetery or crematory: Greenmount Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 11-25-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 24 19 46, at 6:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 24 19 46, to Nov 24 19 46 and that I last saw h.. alive on November 23 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	12 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W A Bridges M. D. or other

Address: Towson 4, Maryland Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

10818 P

Reg. Dist. No. 380

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Baltimore County
County ..... 2607 Hillcrest Ave
City or town ..... Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred: .....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... Md. County ..... Balto.
City or town ..... Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. ..... 2607 Hillcrest Aye.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Angelo Panzarella

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of wife Maria Panzarella
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 8 1879

8. AGE: Years	Months	Days	If less than one day
67		8	..... hrs. ..... min.

9. Birthplace Valle-lunga Italy (Town, county, and state)
10. Usual occupation Shoesmaker
11. Industry or business

FATHER
12. Name Rosario Panzarella
13. Birthplace Italy

MOTHER
14. Maiden name Michela Costanza
15. Birthplace Italy

16. Informant Maria Panzarella (Wife)
Address 2607 Hillcrest Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov.19 1946 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.
19. Funeral director Frank Della Noce
Address 52 N.Morley St.

19. 11-18-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1946, at 7 00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 9, 1946, to Nov. 16, 1946 and that I last saw h... alive on Nov. 15, 1946

	DURATION
Immediate cause of death: Cerebral hemorrhage	1 week
Due to: Hypertension	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Harold a. Gott M.D.
M. D. or other
Address 8100 Harford Rd Date signed 11/16/46

Evidence for change of Informant's name-Undertaker's Statement-in person. 12/9/46 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10819

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Relay, 27, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6/7/46
Hospital, Institution, or street address where death occurred:
Relay Sanitarium
How long in hospital or institution? 6/7/46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore City
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1009 Cathedral Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME
Frank S. Parker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: --
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 1882

8. AGE: Years	Months	Days	If less than one day
64	9		hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business

FATHER 12. Name: John Parker
13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden name: Susan Riley
15. Birthplace: Balto. Md.

18. Informant: Mr. Frank W. Marcks
Address: 3324 Spalding Avenue, Baltimore 15, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-2-46 (month) (day) (year)
Cemetery or crematory: Cathedral Cemetery
Location: Baltimore
18. Funeral director: Loring Byers
Address: 5905 Park Heights Ave

19. 11/30/46 (Date rec'd by registrar) C. W. Reddick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/29/46 19..., at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/7/46 19... to 11/29/46 19...
and that I last saw him alive on 11/28/46 19...

Immediate cause of death	DURATION
Uremia	2 wks.
Due to: Syphilitic meningo-encephalitis	
with cord bladder	several
Due to:	years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lewis P. Tumbo M. D.
M. D. or other
Address: Relay - 27, Md. Date signed: 11/29/46

10820

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9370

CERTIFICATE OF DEATH

Reg. Dist. No. 4X0

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 130 S. Bouldin St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: HOWARD MILTON PETERSEN

3.(b) Social Security Number: 213-05-6341

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Divorced
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10-27-1887

8. AGE: Years	Months	Days	If less than one day
59	0	16	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business
FATHER 12. Name: William Petersen
13. Birthplace: Denmark
MOTHER 14. Maiden name: Susanna Atwell
15. Birthplace: Baltimore, Md.
16. Informant: Registrar's Office, Clin. Records
Address: Vets. Adm. Hosp., Ft.Howard, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/16/46 (month) (day) (year)
Cemetery or crematory: Oaklawn Cemetery
Location: Baltimore, Md.
18. Funeral director: Henry Sander & Sons., Inc.
Address: North Ave. & Broadway, Balto., Md.
19. 11-15-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13, 1946, at 7:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9, 1946, to November 13, 1946
and that I last saw him alive on November 13, 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to: Hypertension arterial	3 Yrs.
Due to:	
Other conditions: Hypertensive heart disease	
Hemiplegia, right	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLINICAL DIRECTOR
Address: V.A. Ft. Howard, Md. Date signed: 11-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

★ 10821 8

Reg. Dist. No. 44 1

1. PLACE OF DEATH:
County: Balto.
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 1400 Block Old Eastern ave,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Essex Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1732 Glen Cuntes Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mallie Phillips

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): April 8 1940

8. AGE:

Years	Months	Days	If less than one day
6			hrs. min.

9. Birthplace: Elkins W Va.
(Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: S Hugh. Phillips
13. Birthplace: W Va.
MOTHER 14. Maiden name: Meda Swecker
15. Birthplace: W Va.
16. Informant: S Hugh. Phillips
Address 1732 Glen Cuntes Rd.
17. removal. Date thereof 11-10-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory:
Location: Elkins W Va.
18. Funeral director: James J Brady & sons
Address 4407 Eastern Ave Rd.
19. 11/9/46 19 C W Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8 1946, at 5 30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 8 1946, to Nov 8 1946
and that I last saw h alive on 19
Immediate cause of death (a) Fracture Comminuted vertebra. DURATION
Due to: Fracture left femur above knee
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 11/8/46
Where did injury occur? Essex (City or town) Balto. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Public Road.
Means of injury: Automobile Injured at work? no

23. SIGNATURE: J. M. Carmine M.D.
Deputy Medical Examiner
M.D. or other
Address: Dundalk, Md. Date signed 11/8/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Reid VS
11/9/46

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

P

10822

CERTIFICATE OF DEATH

Reg. Dist. No. 4 10

1. PLACE OF DEATH
County: Baltimore
City or town: B&O R.R. Philadelphia Rd. (in Bunk House)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. B&O R.R. Off Phila. Rd. (in Bunk house)
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nallie Haywood Poole
3.(b) Social Security Number 579-07-6754

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: —
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): 1886
8. AGE: Years: 60? Months: Days: If less than one day ... hrs. ... min.
9. Birthplace: unk (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: B&O R.R.
FATHER 12. Name: unk
13. Birthplace
MOTHER 14. Maiden name: unk
15. Birthplace
16. Informant: Dr. Carmine (via phone conversation with him) P.R.C.
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 29/46 (month) (day) (year)
Cemetery or crematory: Alms House
Location: Texas, Md.
19. Funeral director: James Buzdzinski
Address: 1407 Eastern Ave Rd
19. 11/29 1946 A. W. Hedrich Registrar
(Date rec'd by registrar)
1-35 S.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 20 1946, at 6 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1946, to Nov 20 1946
and that I last saw h— alive on ... 19
Immediate cause of death: Coronary occlusion — DURATION: Immediate
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?
23. SIGNATURE: J. V. McCarrine M.D. (M.D. or other)
Deputy Medical Examiner
Address: Dundalk Md. Date signed: 11/20/46

3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16823

Reg. Dist. No. 44/

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Md.
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 302 S. Clinton Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: JOHN L. POPP

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Divorced.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6-20-1895

8. AGE: Years	Months	Days	If less than one day
51	4	19	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Barber
11. Industry or business:
FATHER 12. Name: Martin Popp
13. Birthplace: Germany
MOTHER 14. Maiden name: Lena Hahn Popp
15. Birthplace: Germany
16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.
18. Funeral director: John G. Connelly
Address: Essex, Maryland
19. 11/11/46 (Date rec'd by Registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 1946, at 9:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8, 1946, to November 9 1946
and that I last saw h...im alive on November 9, 1946

Immediate cause of death	DURATION
HEMORRHAGE IN TUBERCULOUS CAVITY IN APEX OF LEFT LUNG	Sudden
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Above diagnosis substantiated.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. E. KRUCOFF, M.D.
Address: Fort Howard, Md. Date signed: 11/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

NOV 14 1946
BUREAU F.B.

1-25

2-400

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

10824

Reg. Dist. No. 441

1. PLACE OF DEATH:
County Baltimore
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
438 Rocky Point Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 438 Rocky Point Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JOHN J. PORTER

3.(b) Social Security Number 216-10-8108

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Cora L. Porter
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 30, 1901

8. AGE: Years	Months	Days	If less than one day
45	0	29	hrs. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)
10. Usual occupation Sub-Foreman
11. Industry or business Glenn L. Martin Co.

FATHER
12. Name George H. Porter
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden name Anna M. Helldorfer
15. Birthplace Balto., Md.

16. Informant Mrs. John J. Porter
Address 438 Rocky Point Rd. Balto. 21, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Dec. 2, 1946 (month) (day) (year)
Cemetery or crematory Parkwood
Location Balto., Md.
18. Funeral director Kassabaum Funeral Home
Address 7401 Belair Road

19. Dec. 2 1946 (Date rec'd by registrar) John O. Bruell Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1946 at 12:12 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1942 to Nov. 29 1946 and that I last saw h[illegible] alive on Nov. 29 1946

Immediate cause of death	DURATION
Carcinoma of Rectum	4 yrs
Due to	
Due to	
Other conditions NO	

(Include pregnancy within 3 months of death)

Major findings of operations above
Date of op.
Autopsy results NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James H. White M.D. M. D. or other
Address 7001 Eastern Ave Balto 24, Md. Date signed 12/1/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DEC 9 1946

2-25

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10825

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 9 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Washington, D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 804 Portland St., S.E. Wash., D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: PTE

3.(a) FULL NAME

FLOYD E. POSTON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11-25-1898

8. AGE:	Years	Months	Days	If less than one day
	47	11	19	hrs. min.

9. Birthplace: ?
(Town, county, and state)

10. Usual occupation: ?

11. Industry or business

FATHER
12. Name: Robert F. Poston
13. Birthplace: ?

MOTHER
14. Maiden name: Elizabeth May McGoldrich
15. Birthplace: ?

16. Informant: Registrar's Office, Clin. Records
Address: Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 16 - 1946 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.

18. Funeral director: Oder Funeral Home, Inc.
Address: 4644 York Road
Baltimore, Md.

19. Nov 18 19 46 (Date rec'd by registrar) D. W. Kesnick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14, 1946 at 3:23 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5, 1946, to November 14, 1946 and that I last saw him alive on November 14, 1946

Immediate cause of death	DURATION
Pulmonary Edema	24 Hrs.
Due to: Hemolytic Icterus	2 Days
Anuria	2 Days
Due to:	
Other conditions: Cord Bladder	
Hemiplegia, left.	

(Include pregnancy within 3 months of death)

Major findings of operations: Operation: Transuretheral Resection Date of op. 11-12-46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. C.M.P. or other.

Address: V.A. Ft. Howard, Md. Date signed: 11-14-46

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10826

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 410

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Dundalk Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1202 Mc Elderry Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Eakins Allen Price.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	M

6.(b) Name of husband or wife: Mattie Price
6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1911

8. AGE: Years: 35 | Months: 8 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Chester, S.C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Bethlehem Steel Corp.

FATHER
12. Name: Nathan Price
13. Birthplace: S.C.

MOTHER
14. Maiden name: Mary Thompson
15. Birthplace: S.C.

16. Informant: Mattie Price
Address: 1202 Mc Elderry Court

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 8, 1946 (month) (day) (year)
Cemetery or crematory: St Paul Cemetery
Location: Chester, South Carolina
Elroy O. Wilson

18. Funeral director:
Address: 1000 Brayley Ave

19. 11/7/46 (Date rec'd by registrar) J. McGarrity M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 6 1946 at 10.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 6 1946 to Nov 6/46
and that I last saw h alive on 19

Immediate cause of death	DURATION
Street car accident.	
Fracture clavicle dextra	
Crushed chest, both	
arms crushed, both	
Due to: legs crushed & almost	
Other conditions: severed.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 11/6/46
Where did injury occur? Dundalk (City or town) Balto. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Public Place
Means of injury: Street car Injured at work? No

23. SIGNATURE: J. McGarrity M.D.
Deputy Medical Examiner
Address: Dundalk Md. Date signed: 11/6/46

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 20 1946
BUREAU OF

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

★ 10827

Reg. Dist. No. 38-1

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural near White Hall
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore.
City or town: Rural near White Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.: West Liberty.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Thomas Leib Redding.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Vira Redding.
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): February 20, 1878.

8. AGE: Years	Months	Days	If less than one day
68	9	2	hrs. min.

9. Birthplace: Stewartstown, Pa. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Own farm.

FATHER
12. Name: Elias Redding.
13. Birthplace: Gettysburg.

MOTHER
14. Maiden name: Elizabeth Hedrick.
15. Birthplace: Shrewsbury, Pa.

16. Informant: Mrs. Vira Redding
Address: White Hall, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 25 1946 (month) (day) (year)
Cemetery or ~~crematory~~: Stewartstown
Location: Stewartstown, Pa.

18. Funeral director: Jacob Hartenstein
Address: New Freedom Pa.

19. Nov 26 1946 (Date rec'd by registrar) Chester L. Reaver Registrar
Lucy Rose

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22 1946, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18 1946, to Nov. 22, 1946
and that I last saw h.im alive on Nov. 22, 1946

Immediate cause of death	DURATION
Chronic Pulmonary edema & heart failure due to a chronic myocarditis with advanced arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Norman H. Gemill, M.D. M. D. or other
Address: Stewartstown, Pa. Date signed: Nov. 23 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-25

2-350-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

CERTIFICATE OF DEATH

★ 1083 Reg. Dist. No. 441

2 2

1. PLACE OF DEATH:
County Balto
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
507 Franklin ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Balto
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 507 Franklin ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henry Reuter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife Lena Reuter (nee Rhoerster) 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26 - 1872

8. AGE: Years	Months	Days	If less than one day
74	—	8	hrs. min.

9. Birthplace Germany. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant Sons, and Daughters.
Address 507 Franklin ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/7/46 (month) (day) (year)
Cemetery or crematory Luarty
Location O'Donnell St.
18. Funeral director John D Connelly.
Address 418 Eastern Ave. Essex, Md
19. 11/6/ (Date rec'd by registrar) 19 46 John D. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1946 at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 46 to Nov. 4 19 46
and that I last saw him alive on Nov. 4, 1946 19

Immediate cause of death	DURATION
Cachexia	
Due to Generalized Carcinomatosis	One year
Due to Carcinoma of rectum	1½ years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A L Colachy M.D. M. D. or other
Address Ridge Rd Balt. Date signed Nov. 4, 19

6, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1-25

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-d)

CERTIFICATE OF DEATH

10829 P

Reg. Dist. No. 38 1

1. PLACE OF DEATH:
County: Balto.
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 315 Dixie Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: Balto.
(For newborn infants give residence of mother)
State: Md. County:
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 315 Dixie Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: FLORENCE E. ROBINSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Morris B. Robinson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 26, 1881

8. AGE: Years	Months	Days	If less than one day
65	6	22	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: -
11. Industry or business:

FATHER
12. Name: William T. Fifer
13. Birthplace: Balto.

MOTHER
14. Maiden name: Mary Bailey
15. Birthplace: Balto.

16. Informant: Mrs. W. W. Eckhart
Address: 315 Dixie Drive, Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/20/46 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. Nov. 19 1946 (Date rec'd by registrar) A. M. Kedenck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18, 1946, at 4:33A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 12 1946, to Nov 18 1946
and that I last saw h alive on Nov 18/46 1946

Immediate cause of death	DURATION
Cerebral Thrombosis	2 Yrs
Due to Cancer of Rectum	2 yrs
Due to Metastasis to Liver and Lungs	1 yr
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Eug Komm M. D. or other
Address: 1 E 22 St Balto Md Date signed 11/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

10830

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 9 mos., 27 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 9 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel Co.
City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 218 W. Edgevale Road
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME William R. Rodenhiser

3.(b) Social Security Number 213-07-7369

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15, 1898

8. AGE: Years	Months	Days	If less than one day
48	10	6	hrs. min.

9. Birthplace Elizabeth City Co., Virginia
(Town, county, and state)

10. Usual occupation Pipe Fitter

11. Industry or business

FATHER
12. Name John A. Rodenhiser
13. Birthplace Kent Co., Maryland

MOTHER
14. Maiden name Emma Eckels
15. Birthplace Washington, D. C.

16. Informant William R. Rodenhiser
Address 218 W. Edgevale Rd., Brooklyn Pk. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov. 24, 1946 (month) (day) (year)
Cemetery or crematory Green Lawn Cemetery
Location Newport News, Virginia

18. Funeral director John F. Denny, Inc.
Address 715 Light St., Balto., Md.

19. Nov. 21, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1946 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 25, 1946, to Nov. 21, 1946 and that I last saw him alive on November 21, 1946

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions Pulmonary Tuberculosis	5 Yrs.

(Include pregnancy within 3 months of death)

Major findings of operation No operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other
Address Mount Wilson, Md. Date signed 11/21/46

Rec'd - 11-23-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and complete age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
NOV 26 1946
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2-32a — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

10831

CERTIFICATE OF DEATH

Reg. Dist. No. 371

1. PLACE OF DEATH:

County Baltimore

City or town Texas
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Baltimore County Home

How long in hospital or institution? 10 mo. 25 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Sparks
(If outside city or town limits, write RURAL and give nearest town)

Street No. Sparks (Rural)
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Charles. D. Sanders

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1872

8. AGE:

Years	Months	Days	If less than one day
74	—	1	..... hrs. ..... min.

9. Birthplace Maryland (Rocks Deer Creek)
(Town, county and state)

10. Usual occupation Farm Laborer

11. Industry or business

FATHER
12. Name Drewey Sanders
13. Birthplace ? Maryland.

MOTHER
14. Maiden name Mary V. Pearce
15. Birthplace ? Maryland

16. Informant Harry C. Sanders
Address 6027 Stanton Av. NW. Washington D.C.

17. Burial Date thereof Nov. 22 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

19. Funeral director Landon M. Brooks
Address Sparks, Md.

19. Nov 19 1946 Wm J. Lankford
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1946 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26 1945 to Nov 19 1946 and that I last saw h... alive on Nov 18 1946

Immediate cause of death	DURATION
Chronic Myocarditis	2 yrs
Due to Nephritis - Chronic interstitial	25 yrs
Due to	
Other conditions Dropsy - Chronic alcoholism	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wilmer C. Enson M.D.
M. D. or other

Address Cockeysville Md Date signed 11/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

NOV 22 1946
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1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

10832

Reg. Dist. No. 41

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Turners Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Turners Station
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 117 Central Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Wm F. Schaeffer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary S. Schaeffer
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 21 - 1908

8. AGE: Years	Months	Days	If less than one day
38	0	12	..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Toll Collector
11. Industry or business: Sparrows Pt. Co.

FATHER
12. Name: Wm F. Schaeffer
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Mary Schmidt
15. Birthplace: Baltimore

16. Informant: Mrs. Mary S. Schaeffer
Address: 117 Central Ave - Turners Station

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 7 46 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Baltimore
18. Funeral director: Philip Herweg Sons
Address: 2024 Orleans St.

19. Nov. 5 19 46. (Date rec'd by registrar) G W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3 19 46 at 11:45 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 30th 19 46 to Nov 3rd 19 46
and that I last saw him alive on Nov 3 - 1946 19

Immediate cause of death	DURATION
Carcinoma of Stomach	Indefinite
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Jos. Thomas M.D. M.D. or other
Address: Turners Station Md. Date signed 11-4-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52a

CERTIFICATE OF DEATH

★ 10833

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Balto
City or town: Englishtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: English Town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3612 Annapolis ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME Frank Schneider

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Mary
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 10—16—1872

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
74	0	9		

9. Birthplace: Hungary (Town, county, and state)
10. Usual occupation: Retired Grocery
11. Industry or business:
FATHER 12. Name: Leopold Schneider
13. Birthplace: Hungary
MOTHER 14. Maiden name: Elizabeth
15. Birthplace: Same
16. Informant: Mary Schneider
Address: 3814 Annapolis Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/28—46 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: Ritchie Highway
18. Funeral director: Edward Rondon
Address: 2359 Wash. Blvd.
19. 11—26 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 25 1946, at 1:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1946, to Nov. 25 1946
and that I last saw him alive on Nov. 24, 1946
Immediate cause of death: Adenocarcinoma of right Kidney with general metastases. — DURATION: 1 year
Due to:
Due to:
Other conditions: Hypertensive cardiovascular disease — DURATION: 2
(Include pregnancy within 3 months of death)
Major findings of operations: as above.
Date of op. May 1946
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harry Leibel M.D.
M. D. or other
Address: 1226 Hanover St. Date signed: 11/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING
VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10834 8

Reg. Diat. No. 321

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 7 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2020 N. Calvert St., Baltimore, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Adelaide Schultz

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	married

6.(b) Name of husband or wife: William Schultz

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): September 16, 1908

8. AGE:

Years	Months	Days	If less than one day
38	2		hrs. min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER
12. Name: Frank Seaver
13. Birthplace: Missouri

MOTHER
14. Maiden name: Emma Williamson
15. Birthplace: New Jersey

16. Informant: Hospital Records
Address: Catonsville 28, Md.

17. Cremation
(~~Burial~~, cremation, ~~or removal~~. Which?) Date thereof 11/18/46 (month) (day) (year)

~~Cemetery or~~ crematory: Green Mount

Location: Balto. Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St

19. 11-18 19 H. C. Woodward Registrar
(Date rec'd by registrar)

1-25

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16 19 46 at 6:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 9 19 46, to November 16 19 46 and that I last saw h...er alive on November 16 19 46

	DURATION
Immediate cause of death: Right ventricular hemorrhage (Cerebral)	12 hrs
Due to: Malignant hypertensive cardio-vascular disease	indefin
Due to:	
Other conditions: pregnancy	4 month

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk
Isadore Tuerk
Catonsville 28, Md. M. D. or other

Address: Date signed: 11/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

10835

CERTIFICATE OF DEATH

Reg. Dist. No. 30 /

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years, 24 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 20 years, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 3201 North Calvert Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Thatcher A. Scott

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 22, 1896

8. AGE:

Years	Months	Days	If less than one day
50	8	26	hrs. min.

9. Birthplace: Massachusetts (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: ?

FATHER

12. Name: Charles Scott

13. Birthplace: Canada

MOTHER

14. Maiden name: Eva Waterman

15. Birthplace: Massachusetts

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal, which?) Date thereof 11-20-46 (month) (day) (year)

Cemetery or crematory: South Dartmouth, Mass

Location: South Dartmouth, Mass

18. Funeral director: Geo. G. Beyer Jr.

Address: 151 Hollins St.

19. 11-19- (Date rec'd by registrar) 1946 Harry H. Muller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 17 1946, at 5:40 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 24 1926, to November 17 1946 and that I last saw him alive on November 17 1946

	DURATION
Immediate cause of death: Aplastic anaemia	About 2 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Isadore Tuerk

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 11-18-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

RECEIVED
NOV 20 1946
BUREAU V.S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

83a

10826

1. PLACE OF DEATH

County Baltimore Registration Dist. No. 94

Village or City White House No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME John Franklin Seaks

(a) Residence No. White House St., Ward. 5th District

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie E. Seaks

6. DATE OF BIRTH (month, day, and year) January 25-1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	9	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore Co. Md. (State or country)

FATHER

13. NAME Frederick Seaks

14. BIRTHPLACE (city or town) Germany (State or country)

MOTHER

15. MAIDEN NAME Susan Millinder

16. BIRTHPLACE (city or town) Maryland (State or country)

17. INFORMANT Minnie E. Seaks (wife) (Address)

18. BURIAL, CREMATION, OR REMOVAL Place Grace, Md. Date Nov 22, 1946

19. UNDERTAKER Edward E. Tipton (Address) Hampstead Md.

20. FILED Nov 27, 1946 C. E. Fowble M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Nov. (Month) 19 (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from November 5, 1946, to Nov. 19th 1946.

I last saw him alive on Nov. 19, 1946; death is said to have occurred on the date stated above, at 9:30 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cerebral hemorrhage

Apoplexy – hemiplegia of entire Lt. side.

Date of onset Nov. 5, 7 a.m.

Other Contributory Causes of importance:

Arterio-sclerosis and hypertension – B.P. 200/100

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Cyril E. Fowble M. D.

(Address) Upperco, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN 1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-A)

CERTIFICATE OF DEATH

10837

Reg. Diat. No. 430

1. PLACE OF DEATH:
County: Baltimore
City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
6 Henry Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: As in No 1 Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6 Henry Avenue
(If rural, see LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ida V Shipley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wm H Shipley
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19 1873

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
73	5	14		

9. Birthplace: Baltimore County Md
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER
12. Name: David Gilland
13. Birthplace: Baltimore County Md

MOTHER
14. Maiden name: Mary Crosly
15. Birthplace: Baltimore City Md

16. Informant: David Shipley
Address: 3135 Chesley Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/6/46 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Baltimore Md

18. Funeral director: Lasseahn Funeral Home
Address: 7401 Belair Road Balto 6 Md

19. Nov 3 1946 (Date rec'd by registrar) Mrs C. L. Reipsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 3 1946 3.10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 1945 to Nov. 3 1946 and that I last saw h. ER alive on Nov. 3rd 1946

Immediate cause of death	DURATION
UREMIA	4 WEEKS
CARDIAC FAILURE, TERMINAL	2 days
Due to CARDIO-RENAL VASCULAR DISEASE	15 YEARS
AND	
Due to CHRONIC MYOCARDITIS	2 YEARS
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John H. Hirschfeld M.D. M. D. or other
Address: 6919 HARFORD Rd Date signed: 11/3/1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Dr Jno H Hirschfeld
6919 Harford Rd

11-12 30
6-8

1-3

Dr. Grott

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-1)

CERTIFICATE OF DEATH

10838 Y

Reg. Dist. No. 430

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County Overlea

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
403 Walcott Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Overlea

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 403 Walcott Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Slater

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
feamle	white	widowed

6.(b) Name of husband or wife George Slater

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 1868

8. AGE:	Years	Months	Days	If less than one day
	78			....hrs. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER
12. Name ? Wunderlich
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Family

Address 403 Walcott Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/19/46 (month) (day) (year)

Cemetery or crematory Trinity Cem.

Location Baltimore

18. Funeral director Leonard J. Ruck

Address 5305 Harford Road -14-

19. Nov 18 (Date rec'd by registrar) 19 46 A. H. Helms Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 19 46, at 2 00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19 43, to Nov. 16, 19 46 and that I last saw h.. alive on Nov. 15, 19 46

Immediate cause of death	DURATION
Arteriosclerotic	
cardio-vascular	2 yrs.
disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harold A. Grott, M.D.
M. D. or other

Address 8100 Harford Rd. Date signed 11/18/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

10839 P

Reg. Dist. No. 381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 610 Bosley Ave.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Towson Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 610 Bosley Ave.
(If rural, give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Sanford Smith

3. (b) Social Security Number —

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Annie Corbin Smith

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1863

8. AGE: Years 83 | Months 7 | Days 6 | If less than one day hrs. min.

9. Birthplace Conn.
(Town, county, and state)

10. Usual occupation Electrical Engineer

11. Industry or business Retired

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden name "
15. Birthplace "

16. Informant Mrs. Ross W. Hooper
Address Ellicott City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/21/46 (month) (day) (year)
Cemetery or crematory Prospect Hill Cem.
Location Towson, Md.

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. 11-22 46 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1946, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 1946 to Nov 20 1946, and that I last saw him alive on Nov. 20. 1946.

	DURATION
Immediate cause of death: Heart disease, chronic myocarditis; decompensated	9 mo +
Due to Coronary artery thrombosis	3/20/46
Due to Arteriosclerosis	Unknown
Other conditions Senile changes	Unknown

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Rollin L. Hudson M.D. M. D. or other
Address Towson Md Date signed 11/20/46

1-25 2-380-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10840 P

CERTIFICATE OF DEATH

Reg. Dist. No. 440

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2008 E. Pratt St., Baltimore, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-II (S)

3.(a) FULL NAME: ROY E. SNYDER

3.(b) Social Security Number: 213-09-61111

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Grace Snyder
6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): October 30, 1915

8. AGE:

Years	Months	Days	If less than one day
31	0	16	...hrs. ...min.

9. Birthplace: Alberton, Md.
(Town, county, and state)

10. Usual occupation: Sheet metal worker

11. Industry or business

FATHER
12. Name: Ernest Snyder (deceased)
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Warfield
15. Birthplace: Florence Maryland

16. Informant: Clinical Records Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 19-1946 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: 5501 Frederick Ave., Balto. Md.

18. Funeral director: Oder Funeral Home Inc.
Address: 4644 York Rd., Baltimore, Md.

19. 11/18/46 (Date rec'd by registrar) 19... A M Hodnett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16 19 46 at 6:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7 19 46 to November 16 19 46 and that I last saw him alive on November 16 19 46

Immediate cause of death	DURATION
Multiple Myeloma	3 mos. plus
Due to	
Due to	
Other conditions: Pulmonary congestion, bilateral	1 day

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR.
M. D. or other
Address: VETS. ADM. FT. HOWARD, MD. Date signed: 11-16-46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10841

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

CERTIFICATE OF DEATH

Reg. Dist. No. 310

1. PLACE OF DEATH:
County: Baltimore
City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: ---
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Randalstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Winans Road
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: Annie Elizabeth Stansfield

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Randolph Stansfield
Deceased 6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): January 26,1865

8. AGE: Years	Months	Days	If less than one day
81	8	11	...hrs. ...min.

9. Birthplace: Baltimore County Maryland
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER 12. Name: Clagett
13. Birthplace
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Mr. Sandusky
Address: Winans Road , Randallstown Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: November 9,46 (month) (day) (year)
Cemetery or crematory: Mt. Olive
Location: Randallstown Maryland
16. Funeral director: Frank H. Newell
Address: Pikesville, Maryland
19. 11/6/ (Date rec'd by registrar) 1946 Wm. E. Martus Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6 1946 at 7 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1946, to Nov 6 1946
and that I last saw h... alive on Nov. 6, 1946

Immediate cause of death	DURATION
Cardio-vascular Dis.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Wm. E. Martus M. D. or other
Address: Randallstown Date signed 11/6/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 20 1946
BUREAU OF
2-3J

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52)

CERTIFICATE OF DEATH

10842

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County Baltimore

City or town Arbutus

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 1/2 yrs

Hospital, institution, or street address where death occurred:

4807 Benson ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Arbutus

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4807 Benson ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Gahlia Caroline Stiebing

3. (b) Social Security Number none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: John Frederick Stiebing

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Sept. 15 1894

8. AGE: Years: 62 Months: 2 Days: 0 If less than one day: hrs. min.

8. Birthplace: Baltimore City Md (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Housework

FATHER

12. Name: Martin Albiker

13. Birthplace: Baltimore Md

MOTHER

14. Maiden name: Katherine Brauer

15. Birthplace: Baltimore Md

16. Informant: Mrs. J. F. Stiebing (Husband) Address: 4807 Benson ave, Baltimore 27 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-18-46 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Maryland

18. Funeral director: George L. Schwab

Address: 2101 Frederick Avenue

19. Nov 16 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 15 1946, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1942 to Nov 15 1946

and that I last saw h[illegible] alive on Nov 15 1946

	DURATION
Immediate cause of death: Carcinoma of Bladder 4 yrs	
Due to: Secondary Metastasis 1 yr	
Due to: Myocarditis &	6 mos
Due to: Decompensation	
Other conditions: Hypertension	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. B. Brumbaugh M. D. or other

Address: 5609 Main St Elkridge 27 Md Date signed 11/18/46

RECEIVED
NOV 19 1946
BUREAU OF

1-3J-

Dr. Hirschfield
6919 Harford Rd.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

10843

Reg. Dist. No. 3

1. PLACE OF DEATH:
County Glen Arm
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Long Green Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Glen Arm
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Long Green Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harry Francis Staylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Ida E. Staylor
6.(c) If olive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 9, 1877

8. AGE: Years	Months	Days	If less than one day
69	10	11	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation retired
11. Industry or business

FATHER
12. Name Frank Staylor
13. Birthplace Md.

MOTHER
14. Maiden name Martha Bunce
15. Birthplace Md.

16. Informant Mrs. Ida E. Staylor
Address Long Green Road, Glen Arm,
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/23/46 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Baltimore
18. Funeral director Leonard J. Ruck
Address 5305 Harford Road -14-
19. 11/21 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 19 46 at 3 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 19 46, to Nov 20 19 46
and that I last saw h. l. m. alive on Nov. 19 19 46

Immediate cause of death	DURATION
Chronic myocarditis	2 mos
Due to Pulmonary edema	2 days
Due to Hypertensive Cardio-renal disease	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John H. Hirschfeld M.D. M. D. or other
Address 6919 Harford Rd Date signed 11/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64-2)

CERTIFICATE OF DEATH

10844

Reg. Dist. No. 416

1. PLACE OF DEATH:
County: 1725 Church Road
City or town: Baltimore County, Dundalk, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1725 Church Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: THOMAS FRANKLIN THORNE

3.(b) Social Security Number: 213-07-7752

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Ruth McGinley
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Dec. 3, 1903

8. AGE: Years	Months	Days	If less than one day
42	11	26	...hrs. ...min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation:
11. Industry or business: Beth. Steel, Sp. Pt., Md.

FATHER
12. Name: Thomas F. Thorne
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Lelia Boone
15. Birthplace: North Carolina

16. Informant: Mrs. Ruth Thorne - widow
Address: 1725 Church Road, Dundalk - 22

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-1-46 (month) (day) (year)
Cemetery or crematory: OAK LAWN CEMETERY
Location: BALTIMORE, MARYLAND

18. Funeral director: HENRY SANDER & SONS, INC.
Address: NORTH AVE. & BROADWAY

19. 11/30 (Date rec'd by registrar) 19 46 A. M. Hedrick Registrar
1-25-47 gw

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29 19 46 at 6.15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
GUN SHOT WOUND THRU HEART CHEST + HEART	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 11-29-46
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: SHOT by 22 CAL. Pistol Injured at work?

23. SIGNATURE: M Rogers M.D.
Dept. Med. Exam. - Balto. Co. M.D. or other
Address: Date signed: 11/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

* 10845

Reg. Dist. No. 373

2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.

1. PLACE OF DEATH:
County Baltimore Md.
City or town Cockeysville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs
Hospital, Institution, or street address where death occurred: Masonic Home, Cockeysville Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 417 E. 31st St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Lida Ann Townsend

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife John Phillip Townsend
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1862

8. AGE: Years	Months	Days	If less than one day
84	2	13	hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation Seamstress
11. Industry or business
FATHER 12. Name Samuel Carson Chaney
13. Birthplace Ireland
MOTHER 14. Maiden name Caroline Stein
15. Birthplace Baltimore, Md
16. Informant Laura M. Schroeder
Address Masonic Home, Cockeysville
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-12-46 (month) (day) (year)
Cemetery or crematory Greenmount
Location Baltimore Md
18. Funeral director Wm. Cook
Address St. Paul & Preston St.
19. 11-10-46 (Date rec'd by registrar) L. M. Schroeder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 19 46, at 11 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 19 46, to Nov. 9 19 46
and that I last saw h ed alive on Nov 9 19 46

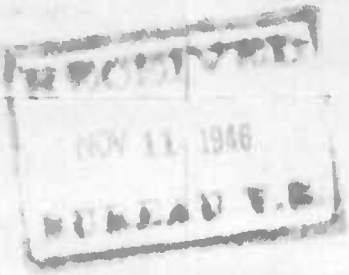
Immediate cause of death	DURATION
Cardiac Failure	1 mnth
Due to Arterio Sclerosis	6 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter J. Kees M. D.
M. D. or other
Address Cockeysville Md Date signed 11/9/46



1-25

2-370. ——————————— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

10846

Reg. Diat. No. 310

1. PLACE OF DEATH:
County Baltimore
City or town Holbrook
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Randallstown P.O.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Holbrook
(If outside city or town limits, write RURAL and give nearest town)
Street No. Randallstown P.O.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Horace Elie Triplett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Bessie Nettie Dell
6.(c) If alive, give age 80 years
7. Birth date of deceased (mo., day, yr.) Dec. 15, 1864

8. AGE: Years	Months	Days	If less than one day
81	11	11	....hrs. ....min.

9. Birthplace Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Elie Triplett
13. Birthplace Md.

MOTHER
14. Maiden name Louisie Barnes
15. Birthplace Md

16. Informant Mrs. Jesse Triplett
Address Randallstown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 30 1946 (month) (day) (year)
Cemetery or crematory Woods Chapel Cem.
Location Liberty Rd. Balto Co. Md.
18. Funeral director C. Harry Ware
Address Sykesville, Md.
19. 11/27/ 1946 (Date rec'd by registrar) Wm. E. Martens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1946, at 2:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to Nov. 27, 1946 and that I last saw him alive on Nov. 26, 1946

Immediate cause of death	DURATION
(a) Uremic poisoning	
Due to (b) Chronic prostatitis	
Due to (c)	
Other conditions Hypertrophy of Prostate	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. E. Martens M. D. or other
Address Randallstown Date signed 11/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Une correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
DEC 6 1946
BUREAU OF S.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 10847 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 823 Bond Street (If rural, give LOCATION)
2.(a) If veteran, name war: Veteran

3.(a) FULL NAME James Urbanski

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 13, 1899

8. AGE: Years 47 | Months 2 | Days 22 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Seaman
11. Industry or business: Merchant Marine

FATHER
12. Name: William ~~Urbanski~~ URBANSKI
13. Birthplace: Poland

MOTHER
14. Maiden name: Elizabeth ?
15. Birthplace: Germany

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/6/46 (month) (day) (year)
Cemetery or crematory: Holy Rosary
Location: German Hill Rd
18. Funeral director: Lilly & Tilden
Address: 403 E. Preston St.

19. Nov 6 1946 (Date rec'd by registrar) A. W. Hedrick M.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4 1946, at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21 1946, to November 4 1946 and that I last saw him alive on November 4 1946

Immediate cause of death	DURATION
Chronic myocarditis	Indefinite
Due to: Chronic alcoholism	"
Due to: Central Nervous System syphilis, type undetermined.	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other
Address: Catonsville-28, Md. Date signed: 11-4-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

Reg. Dist. No. 10848 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto.

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

28 N. Symington Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 28 N. Symington Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: EREMA G. WETZEL

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Robert G. Wetzel

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10, 1888

8. AGE: Years	Months	Days	If less than one day
58	4	29	hrs. min.

9. Birthplace: Pittsburgh, Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: William M. Dunne

13. Birthplace: Ireland

MOTHER 14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Mr. William J. Haid, Jr. son

Address: 22 Holmehurst Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/12/46 (month) (day) (year)

Cemetery or crematory: Meadow Ridge Memorial Pk.

Location: Washington Blvd., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 11/11 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 9, 1946 at 10-40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/20 19 46, to 11-9- 19 46 and that I last saw her alive on 11-9-46 19

Immediate cause of death	DURATION
Carcinoma of Stomach	2 years
Due to metastesis to liver. Small intestine & gall bladder -	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no operation -

Date of op.

Autopsy results: no -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Edwin J. Ward M.D. M. D. or other

Address: 313 N. Paca, Date signed 11-11-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 10849

Reg. Dist. No. 4-20

1 2

1. PLACE OF DEATH:

County: Relay Rolling Road Balto

City or town: Relay (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: 1530 Rolling Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Relay. Balt

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. 1530 Rolling Road (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Arthur L. Wheeler Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 28 - 1942.

8. AGE:

Years	Months	Days	If less than one day
4	9.	7.	hrs. min.

8. Birthplace: Relay Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Arthur L. Wheeler.

FATHER — 13. Birthplace: Minneapolis Minn

MOTHER — 14. Maiden name: Inez Tessenden

MOTHER — 15. Birthplace: Balto Md.

16. Informant: Arthur L. Wheeler

Address: 1530 Rolling Road.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: Nov. 7-1946 (month) (day) (year)

Cemetery or crematory: Loudens Park Cem.

Location: Baltimore Md.

18. Funeral director: Manro Bark & Sykes

Address: 1600 N. North Ave.

19. Nov 6 19 46 E. Keiffer Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4 19 46, at 12 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Fracture vertebrae Cervical	
Due to: Fracture left humerus	
Due to: Accident due to	
Other conditions: falling of platform	Instantly

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Nov 4 46

Where did injury occur? Relay (City or town) Balt (County) Md (State)

Injured at home, farm, industry, public place (where?): Farm

Means of injury: falling platform fr. car Injured at work? No

23. SIGNATURE: G. M. Kieffer Dep Med Exam M. D. or other

Address: 610 Leads Ave Date signed: Nov 6 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
NOV 8
1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

10850

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Frederick Rd at 8 Mile post
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Catonsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Frederick Rd at 8 Mile post
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Oscar L Whiting

3. (b) Social Security Number:

4. Sex: Male | Color or race: Col | 6.(a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Lillian Whiting

B(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 15 1893

8. AGE: Years: 53 | Months: 7 | Days: 10 | If less than one day: hrs. min.

9. Birthplace: Federal Md
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER
12. Name: Lee Whiting
13. Birthplace: Md

MOTHER
14. Maiden name: Mat. Brown
15. Birthplace: Md

16. Informant: Lillian Whiting
Address: Fred. Rd Catonsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov-27-46 (month) (day) (year)

Cemetery or crematory: Baltimore National Cem

Location: Baltimore Md

18. Funeral director: Mrs Frances A Hemsley

Address: 518 W. Biddle St

19. 11/26 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 25 1946, at 2:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ---- 19---, to ---- 19---, and that I last saw h---- alive on ---- 19---.

Immediate cause of death: Coronary occlusion — DURATION

Due to:

Due to: sudden death

Other conditions: Injury
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: G. M. Kieffer M.D. Catonsville Balto
M. D. or other
Address: 1010 Leadenhall Date signed: Nov. 25 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 1320

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Pikesville Farms
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Pikesville Farms
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Nelson Road
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3.(a) FULL NAME: Joseph Wiley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife: Cora J.Wiley

B.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): March 15,1882

8. AGE: Years	Months	Days	If less than one day
64	8	15	....hrs. ....min.

9. Birthplace: Baltimore Maryland
(Town, county, and state)

10. Usual occupation: Gardner

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Cora J.Wiley
Address: Nelson Road, Pikesville 8, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 3,1946 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville, Maryland

19. Funeral director: Frank H.Newell

Address: Pikesville, Maryland

19. 12-2-1946 Dr E.E. Michols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30, 1946 at 12.30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from about 5 June 1946 to 11/30 1946 and that I last saw h... alive on Nov 25 1946

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to: Coronary Artery	2
Disease	
Due to:	
Other conditions Arterio Sclerosis	2

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E.E. Michols M.D.
M. D. or other

Address: Pikesville 8 Md. Date signed: 12-2-46

DEC 3 1946

1-35

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10852

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Balto
City or town: Middle River (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: Middle River
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Middle River (If outside city or town limits, write RURAL and give nearest town)
Street No.: Glenwood Ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Walter E. Wilkinson

3.(b) Social Security Number: 219-14-1578

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? ? 1880

8. AGE: Years: 66 Months: ? Days: ? If less than one day: hrs. min.

8. Birthplace: Balto. Co. Md (Town, county, and state)
10. Usual occupation: retired fireman
11. Industry or business: Balto. City Md.
FATHER 12. Name: Wm S Wilkinson
13. Birthplace: Balto. Co. Md.
MOTHER 14. Maiden name: Mary E. Biddison
15. Birthplace: Balto. Co. Md.
18. Informant: Mr. Benj. Wilkinson
Address: Carroll Island Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/17/46 (month) (day) (year)
Cemetery or crematory: Orem Methadist
Location: Balto. Co. Md
18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Rd.
19. NOV 15 1946 (Date rec'd by registrar) John D. Gormley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14th 1946, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1946, to Nov 14 1946
and that I last saw h. liv. alive on Nov. 6 1946
Immediate cause of death: Coronary Thrombosis — DURATION: —
Due to: Arteriosclerotic Cardiovascular Disease — DURATION: 7
Due to: Generalized Arteriosclerosis — DURATION: 9
Other conditions: — DURATION:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Leonard Brill M.D. M. D. or other
Address: 826 N. Washington St. Date signed: Nov 14, 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

10853

Reg. Dist. No. 430

1. PLACE OF DEATH:

County Balto

City or town Fullerton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred: Lincoln Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Balto

City or town Fullerton (If outside city or town limits, write RURAL and give nearest town)

Street No. Lincoln Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME CHARLES A WILSON.

3.(b) Social Security Number 215-01-3983

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Elsie Wilson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 3 1888

8. AGE: Years	Months	Days	If less than one day
58	2	11	..... hrs. ..... min.

9. Birthplace Balto Co Md (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Bus Co

FATHER 12. Name Ben Wilson

FATHER 13. Birthplace Balto Co Md

MOTHER 14. Maiden name Jennie Amos

MOTHER 15. Birthplace Balto Co Md

16. Informant Mrs C A Wilson

Address Lincoln Ave Fullerton

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/18/46 (month) (day) (year)

Cemetery or crematory Parkwood

Location Balto Md

18. Funeral director Lassahn Funeral Home

Address 7401 Belair Rd

19. Nov 15 1946 Mrs O. L. Reifsnider

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1946, at 5:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 1945, to Nov 14 1946

and that I last saw h[illegible] alive on Oct 15 1946

Immediate cause of death	DURATION
Cerebral haemorrhage	6 hrs.
Due to Hypertensive Cardio-vascular disease	3-4 yrs
Due to Arteriolar nephrosclerosis	,
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H L Fuller M. D. or other

Address Ridge Rd Balto Md Date signed Nov 14 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(H) MARGIN RESERVED FOR BINDING

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NOV 20 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Dundalk (If outside city or town limits, write RURAL and give nearest town)

Street No. 7100 Martell ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph. S. Wrobleuski.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Julia Wroblewski

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 2/25/1868

8. AGE: Years: 78 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Copper works

11. Industry or business:

FATHER — 12. Name: John Wroblowski

13. Birthplace: Germany

MOTHER — 14. Maiden name: Dont Know

15. Birthplace: Germany

16. Informant: Adam Wroblowski

Address: 7100 Martell ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 3/1946 (month) (day) (year)

Cemetery or crematory: Sacred Heart Cem

Location: Rural

18. Funeral director: Ulrich Funeral Home

Address: 2008 Orleans St

19. Dec 2 1946 (Date rec'd by registrar) A. W. Helms Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 30 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from FEBRUARY 1946, to NOVEMBER 1946

and that I last saw him alive on NOVEMBER 15 1946

	DURATION
Immediate cause of death: HEART FAILURE	3 MO
Due to: ARTERIO SCLEROTIC HEART DISEASE	?
Due to:	
Other conditions: CARCINOMA OF LEFT LUNG	?

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:

Autopsy results: NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stefhow P. Mackowiak M.D. M. D. or other

Address: 6714 Holabird Ave Date signed: Nov. 30 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15